Implementation Plan

Florida's Managed Medical Assistance Program

October 30, 2013

1115 Research and Demonstration Waiver

This page intentionally left blank.

Table of Contents

List of Tables

I. Executive Summary

This document summarizes the implementation schedule and key activities the Agency for Health Care Administration (the Agency) has undertaken or will undertake to implement the Managed Medical Assistance (MMA) program. The following is a brief overview of the waiver, program goals, overall objectives and consumer protections.

During implementation, the Agency will focus on four key objectives, with meeting these objectives constituting a successful rollout.

- First, the rollout in each region must preserve continuity of care. This entails, to the greatest extent possible, that recipients can keep their current primary care provider and their current prescriptions, and no recipient will have an ongoing course of treatment interrupted.
- Second, the plans in the rollout must have sufficient and accurate networks under contract and taking patients, so as to allow an informed choice of plans for recipients and the ability to make appointments.
- Third, the plans in the rollout must have the ability to pay providers fully and promptly to preclude any provider cash flow or payroll issues. This includes giving providers ample opportunity to learn and understand each plan's prior authorization procedures.
- Fourth, the Agency's choice counseling call center and website must be able to handle the volume of recipients engaged in plan choice at any one time.

A. Waiver Overview

Florida's Section 1115 Research and Demonstration Waiver, entitled "Managed Medical Assistance Waiver," (#11-W-00206/4), is designed to implement a new statewide managed care delivery system that will improve outcomes, improve consumer satisfaction, reduce and control costs and 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 positive and negative incentives for plans.

In addition, the following three statewide programs will transition January 1, 2014 under the authority of the MMA Waiver as they operate today and as specified in Special Term and Conditions #70 and #71 of the approved waiver.

- The Healthy Start Program;
- The Program for All Inclusive Care for Children; and
- The Comprehensive Hemophilia Management Program

The MMA program was established as a component of the Statewide Medicaid Managed Care program in Part IV of Chapter 409, Florida Statutes, by the Florida Legislature in 2011. The MMA program is guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. The following paragraphs outline the MMA program goals, objectives and consumer protections. A detailed description of the MMA program is available on the Agency's Website: http://ahca.myflorida.com/smmc.

B. Goals and Objectives

1. Goals and Objectives: The goals of the MMA program are to improve outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The Agency envisions a Medicaid program where all recipients will choose their MCO from a list of nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. 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. The overall program objectives are:

- Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving 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).
- Enhancing fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems. Strict financial oversight requirements are established for managed care organizations (MCOs) to improve fiscal integrity.

C. Consumer Protections

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

1. Increasing recipient participation on Florida's Medical Care Advisory Committee and convening smaller advisory committees to focus on key special needs populations;
2. Ensuring the continuation of services until a primary care or behavioral health provider reviews the enrollee's treatment plan;
3. Ensuring immediate review of recipient complaints, grievances and appeals for resolution as part of the Rapid Cycle Improvement Process;
4. 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 medically approved alcohol or substance abuse recovery program;
5. Requiring Florida's External Quality Review Organization to validate each plan's encounter data;
6. 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;
7. 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;
8. Enhancing metrics on plan quality and access to care to improve plan accountability; and

9. Creating a comprehensive and continues state quality strategy to focus on all aspects of quality improvement in Medicaid.
10. Adding benefits, particularly dental care, disease management and other initiatives that improve health outcomes.

Remainder of page intentionally left blank.

II. Phased Implementation

A. Implementation Overview

The Agency will phase-in the implementation of the program and has carefully planned the transition of the affected recipients to preserve continuity of care. The Agency will follow a multi-layered approach when transitioning recipients into the program by:

- Coordinating with the contracted plans and the Agency's choice counseling vendor to create a phased transition to ensure that the volume of recipients being transitioned occurs in an organized manner. This will allow recipients to access choice counseling in stages via phone or via internet, and will make it easier for the Agency and its choice counseling vendor to provide excellent customer services during the roll out.
- Planning, organizing and implementing a thorough desk and on-site 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.
- Ensuring continuity of care and continued availability of current primary care and behavioral health providers with the new plan by monitoring plan network participation.
- Ensuring appropriate and timely notice to recipients, including outreach and education to locations and providers frequented by impacted recipients to help recipients understand the changes that are occurring.
- Engaging key stakeholders and advocacy groups as well as monitoring complaints through the Rapid Cycle Improvement Process.

Appendix I provides a list of the key implementation activities the Agency has or will undertake to implement the MMA program.

B. Implementation Schedule

Table 1 provides the phased implementation schedule for the MMA program. The estimated total enrollment for the MMA program is 3,071,171 recipients in state fiscal year 2014-2015. This projection is based upon the proportion of the total Medicaid population eligible for the MMA program, applied to the Long Range Economic and Demographic Research forecast for the Medicaid caseloads in state fiscal year 2014-2015. Table 2 located on the following page shows the projected regional enrollment in state fiscal year 2014-2015.

Table 1
Draft Implementation Schedule

Regions	Enrollment Date	Projected Enrollment
2, 3 and 4	May 1	681,108
5, 6 and 8	June 1	811,372
10 and 11	July 1	828,486
1, 7 and 9	August 1	750,205

Table 2 Projected Enrollment by Region for State Fiscal Year 2014-2015	
Managed Medical Assistance Regions	**Projected Enrollment**
Region 1: Escambia, Okaloosa, Santa Rosa, Walton	103,383
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington	118,181
Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union	260,346
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia	302,581
Region 5: Pasco, Pinellas	189,529
Region 6: Hardee, Highlands, Hillsborough, Manatee, Polk	413,256
Region 7: Brevard, Orange, Osceola, Seminole	388,517
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	208,587
Region 9: Indian River, Martin, Okeechobee, Palm Beach, St. Lucie	258,305
Region 10: Broward	253,299
Region 11: Miami-Dade, Monroe	575,187

Source: Florida Agency for Health Care Administration, October 2, 2013.

C. Implementation Triggers, Risks and Mitigation Strategy

The triggers and risks that would prevent the Agency from proceeding with implementation include:

- System failures that prevent recipients from plan enrollment;
- Lack of choice of two plans in a region due to unresolved litigation (bid protests);
- Failure of selected plans to meet the readiness review standards and more specifically failure of the plans in the a region to, in the aggregate, build networks sufficient to service the regions population;
- Systems failures that compromise ongoing courses of treatment and that cannot be resolved through a rapid improvement process.

The triggers and risks described above are also the circumstances that would stop the Agency proceeding with implementation to the next region.

The Agency will use the following mitigation strategies for the identified risks that could prevent proceeding with implementation in a region:

- The Agency will monitor the enrollment process daily to determine if any systems issues have developed that prevent recipients from enrolling in their selected plan. The enrollment process the Agency uses has been operational for many years and has effectively functioned during the roll out of the Long-term Care program. The Agency does not anticipate significant problems in this area but will monitor the enrollment process daily to ensure problems are resolved immediately.
- The Agency is working through the competitive procurement bid protest process. The Agency will not implement the program in a region that does not have at least two plans available.

- The Agency will conduct the plan readiness review process to ensure all plans are ready to accept recipients upon implementation and have networks in place to serve them. The plan readiness review process is outlined in Section II.J of this document. The Agency will notify the Centers for Medicare and Medicaid Services at least 30 days in advance of conducting on-site readiness review of the plans.
- The Agency has established a Rapid Cycle Improvement Process to address recipient complaints including complaints about disruption in services. The Agency has historically resolved recipient complaints quickly as demonstrated in the quarterly and annual reports. A description of the Rapid Cycle Improvement Process is provided under Section II.E of this document.

The Agency's fail-safe or back-up plan in the event that the mitigation strategy fails is to allow recipients to access the Medicaid fee-for-service system.

D. Implementation – Stakeholder's Role

Stakeholder feedback will be reviewed and taken into consideration when determining further implementation of the program to the next region. Stakeholder feedback is a valued component of the Agency's continuous quality improvement strategy to ensure recipients have access to high quality services through the selected MMA plans. The Agency will closely monitor stakeholder feedback through the Rapid Cycle Improvement process described below.

E. Rapid Cycle Improvement Process

Complaints received by the Agency regarding the MMA plans will provide the Agency with feedback on the operation of the program. Complaints may come from recipients, advocates, providers and other stakeholders and are triaged through the Medicaid managed care complaint center.

MMA complaints are submitted to the SMMC complaint center via the online complaint form where they are then recorded, triaged and tracked by SMMC complaint center staff. Complaints are then assigned to and researched/resolved by Florida Medicaid field staff and/or Headquarters staff, depending on the nature and complexity of the complaint. Some complaints are referred directly to the MMA plan for resolution, and the Agency will track these complaints to ensure resolution. Agency staff will use the Complaints/Issues Reporting and Tracking System, which will allow for real-time, secure access through the Agency's web portal. During implementation, the SMMC complaint center will provide a daily report of recorded MMA complaints by complaint type. The daily report will be used to quickly identify and resolve critical issues. The Agency will also track the complaints by plan to review complaint data on individual plans on a weekly basis during the first 90 days of implementation in a region. After the first 90 days of implementation, the complaints will be tracked by plan on a monthly basis to review complaint data on individual plans.

F. Comprehensive Outreach and Education Strategy

1. Overall Outreach and Communication Strategy

The Agency has developed a multi-pronged outreach and communication strategy for sharing information about the MMA program. The Agency has separate strategies for outreach to recipients, providers and other stakeholder groups, yet there are some common resources available to all audiences. For example, the Agency has created a dedicated Website,

www.myflorida.com/SMMC, specifically for the Statewide Medicaid Managed Care (SMMC) program. The Website has dedicated sections for both the Long-term Care (LTC) program and the MMA program. The Website includes a calendar of events, which will be populated with the dates of mailings, webinars and public meetings. It also displays the email address dedicated to the SMMC program (FLMedicaidManagedCare@ahca.myflorida.com) where questions, comments or concerns can be submitted. All questions are responded to and included in the posted Frequently Asked Questions document. The posted Frequently Asked Questions document is in a searchable PDF format with a table of contents and includes sections for LTC and MMA. The posted Frequently Asked Questions document is updated regularly with new questions and includes the date for which the most recent update was made.

Earlier this year, the Agency developed profiles on Facebook, Twitter and YouTube to post information about SMMC program features, updates, resources, dates of importance and webinars. The Facebook and YouTube profiles can also accept reports of complaints or concerns through a private message.

Another communication resource that crosses all three outreach groups is the SMMC interested parties email list-serve, which currently has 4,257 individuals signed up. Anyone who is interested in learning more about the SMMC program and would like to receive an email alert when key new information is available, for example when guidance statements are released and webinars are scheduled, may be added to the distribution list by signing up on the Agency Website.

With the MMA program being the second phase of SMMC to be implemented, the Agency has been broadly communicating about it for more than two years since the legislation that created the program became law. Since that time, the Agency has shared information about both LTC and MMA to stakeholder groups. The communication and outreach strategy delineated in this document is a prospective plan for MMA-specific communication activities, which are anticipated to begin in December 2013.

2. Recipient Outreach

Of utmost concern is direct, clear and timely communication to recipients. The primary method of direct communication with recipients is via letter mailed to their address of record. The Agency plans to send a “pre-welcome” letter to each recipient 120 days ahead of the “go live” date for their respective region. The pre-welcome letter introduces the new program and places the recipient on alert for forthcoming correspondence about the upcoming plan choice. Approximately 60 days before implementation in a region, recipients will be mailed a welcome letter, a packet of information about the plans available in their region and information about accessing the available choice counseling services. Recipients who do not select a plan by 30 days before implementation will receive a third letter reminding them to make their plan choice by an assigned date or they will be automatically assigned to the plan listed in their letter.

The Agency continues to use choice counseling services to assist recipients. Recipients are encouraged to use the choice counseling services to learn more about the plans that will be offered in their areas and to make their plan selection. The Agency will have a call center, located in Tallahassee as well as 22 contracted field staff and an additional local Medicaid office staff who will be certified choice counselors to assist in person. The Agency’s choice counseling vendor, Automated Health Systems, will also conduct an outbound call campaign. Field choice counseling efforts and outbound calls will focus on recipients with special needs who may require additional assistance in choosing a plan.

The Agency has previously been successful in using traditional media outlets to assist with sharing information. In addition, the Agency has previously been successful in submitting guest columns that contain information about the program and upcoming choice timeframes in local newspapers. This strategy was used during the LTC program implementation as another avenue to notify recipient that (1) they should have already received at least one letter from the Agency about the new program and (2) the date by which the recipient should select their plan before auto assignment will take effect. This is a very broad strategy, but one that notifies both recipients and the general public about the program.

3. Provider Outreach

Communication to providers, directly and via their respective membership associations, is the second layer of the Agency's outreach and communication strategy. The earliest official communication about the MMA program to service providers will likely come from provider alert emails and via the Agency's quarterly provider bulletin. These avenues are used to educate providers about resources, guidance statements, upcoming trainings and other relevant information. Provider alert emails are sent on an as needed basis, and provider bulletins are distributed and posted on the Agency's Website quarterly.

Similar to the LTC program communication strategy, the Agency will host many webinars of varying topics including MMA 101, Choice Counseling, specific provider related issues, transition of special populations continuity of care requirements, and more. Questions submitted through the webinars are responded to during the live event and are also answered in writing as well as incorporated into the Frequently Asked Questions document that is posted on the SMMC Website. It is anticipated webinars will begin at least 90 days ahead of implementation in the first region, will continue through all regions going live and will not cease until the Agency feels additional webinars are no longer requested or necessary based on feedback received from providers or their respective associations. Webinars will continue to be recorded and posted via the Agency's YouTube and Slideshare accounts so they remain available at all times for anyone to view and/or download.

The Agency plans to engage providers in each region directly with educational sessions specific to the different provider types. These meetings will be scheduled approximately 60-90 days ahead of the regional "go live" date. The Agency will also engage with providers via local events and as requested.

The Agency has begun engaging provider associations about MMA through formal correspondence and, at about the same time, the mailing of recipient letters will begin and the provider webinar series will be initiated. After this time, the Agency will keep open lines of communication with many of the associations via targeted emails and regular phone calls that will occur through the full MMA program implementation. Similar to LTC, the Agency will share articles, guest columns and resources with the provider associations for them to share with their membership via email or newsletter according to their respective schedules. In addition, the Agency, if invited, will participate in the various association's meetings and conferences.

The Agency currently has field staff who host weekly conference calls and webinar trainings for LTC network providers beginning two weeks prior and continuing four weeks into each region's rollout. These calls serve as a forum for specific provider types to ask questions relating to the program and to notify the Agency of any issues occurring during the transition period. This method has proven effective in identifying the training sessions and additional resources

network providers need to ensure success in their region. The region based conference calls and webinar trainings have given the providers immediate technical assistance as well as the opportunity to troubleshoot any obstacles along the way. The Agency plans to use this method for implementation of the MMA program as well.

4. Other Stakeholder Outreach

The Agency also believes in effective communication to other stakeholder groups. The MMA plans, executive and legislative staffs, sister state agencies, advocacy groups, the media and the general public are all included in this group.

Managed Medical Assistance plans: The Agency will hold calls with plans on a regular basis to share new program information, troubleshoot concerns, and discuss the transition status. The Agency anticipates holding weekly plan calls to address specific readiness issues and the transition of special populations.

Executive and Legislative Members and Staff: Agency leadership regularly meets with members of the executive and legislative branches to share information and provide written updates about the implementation of the SMMC program. These meetings will continue through the end of the implementation of the MMA program. The Agency will make presentations at legislative committee meetings during committee weeks and during legislative session, as well as other times as requested, to ensure legislators are informed about the status of implementation of the program.

Other State Agencies: Similar to communication with the providers and their associations, the Agency will send out guest columns, inclusive of resources and frequently asked questions to our sister agencies for sharing and distribution to their staff and inclusion in their respective newsletters. Agency leadership will also send targeted emails with specific resources ahead of implementation, for example, how to field calls about the program and where to direct callers who may have questions about a variety of topics. The Agency will also host specific training sessions for fellow state agencies as necessary.

Advocacy groups: Similar to the outreach activities conducted for other groups, the Agency will make targeted calls and send targeted emails to different advocacy groups to ensure they are educated about the program and timeframes for recipient communication and implementation. The Agency plans to share the recipient letters with key advocacy groups for their review and feedback prior to finalizing the correspondence.

5. Media and the General Public

The Agency will use traditional and new media avenues to relay information about the MMA program through implementation and after. Press releases are anticipated to occur that announce the pre-welcome letters being mailed as well as the go live date in each region. Facebook, Twitter and YouTube will also be used to share resources, webinars and as a means of interacting with the general public about the MMA program. The Agency anticipates hosting a public kickoff event for the launch of the MMA program where the plans, media, legislators and other stakeholders will also be invited.

6. Outreach Schedule

Appendix II provides the draft Comprehensive Outreach Schedule. The outreach schedule will be continually updated and will be provided to the Centers for Medicare and Medicaid Services regularly.

G. Recipient Enrollment

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 Centers for Medicare and Medicaid Services that it will comply with section 1932(a)(3) of the Social Security Act (SSA) and 42 Code of Federal Regulations (CFR) 438.52, relating to choice since at least two options will be available in all MMA regions.

2. Enrollee Information

The Agency's choice counseling vendor will ensure that enrollees are provided with full and complete information about their plan options. The Agency's choice counseling vendor will provide information regarding an individual's choice to select a plan.

Through the Agency's choice counseling vendor, the Agency will develop enrollee education materials 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 choice counseling vendor will provide information on selecting a plan.

As it does now, the Agency's designated choice counseling vendor 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 information and contact information. In addition, the Agency will supplement coverage information by posting performance information on each plan once such data is available. Information provided will include enrollee satisfaction survey results and performance measure data.

Enrollment materials will be provided in a variety of ways including print, telephone, online and face-to-face. All written materials will 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 choice counseling vendor will also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY. The choice counseling vendor will operate a toll-free number that individuals may call to ask questions and obtain assistance on plans. 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.

Individuals in mandatory groups for the MMA program will receive information (mandatory new eligible packet) about the plan choices in their region and will be informed of their option to select an authorized plan or be assigned to a plan. The choice counseling vendor will:

- Send a pre-welcome letter to each recipient 120 days prior to the MMA program "go-live" date by region. The pre-welcome letter will describe the MMA program. It places the recipient on alert for forthcoming correspondence about the upcoming 30 day plan choice period.

- Mail a welcome letter, packet of information about the MMA plans available in his or her region and information about accessing the choice counseling services approximately 60 days ahead of implementation.
- For recipients who do not choose a plan 30 days ahead of the go live date, send a third letter reminding them to make their plan choice by the assigned date or they will be automatically assigned to the plan listed in their letter.
- Upon the enrollment, the plan will send the recipient a welcome and enrollment packet.

The Agency assures the Centers for Medicare and Medicaid Services that it will provide information in accordance with Section 1932(a)(5) of the SSA and 42 CFR 438.10, Information Requirements.

H. Continuity of Care Provisions

The MMA program increases consumer protections as well as quality and access to care for eligible Medicaid recipients as noted earlier under Section I.C of this document. Key continuity of care provisions include:

- The auto-assignment process - If a recipient does not make an active selection to enroll in an MMA plan during the selection period and their existing plan was selected as an MMA plan, the recipient will remain in the plan (now an MMA plan). This process will ensure recipients stay in the same plan and with the same provider(s) whenever possible.
- The continuation of services - For at least 60 calendar days after the effective date of enrollment or until the primary care or behavioral health provider reviews the enrollee's treatment plan, recipients will receive the same prior authorized or scheduled course of treatment with their existing provider. The plans are also required to reimburse providers whether the provider is under contract or an out of network provider. This contract provision ensures payment by the MMA plans to non-participating providers.
- Prescription drugs - For the first year of operation the plans are required to cover all prescription drugs on the Agency's preferred drug list. The plans are prohibited from having prior authorization or step therapy edits that are more restrictive than the Agency's prior authorization or step therapy edits. This contract provision will allow for a smooth transition by ensuring recipients continue to receive the same drugs they are currently prescribed.

In addition to the continuity of care provisions described above, the Agency negotiated the following added benefits with select MMA plans to improve quality and access to care:

- Enhanced provider network standards ensuring the plans have robust primary care and specialty provider networks;
- Increased number of primary care and specialist providers in a region that are accepting new Medicaid recipients;
- Increased number of primary care providers that offer after hour appointment availability;
- Established utilization rates for out-of-network specialty care and hospital admissions;
- More timely processes for standard and expedited prior authorization requests. For many of the standards, the timeframes for processing the authorization request have been reduced by almost half;

- Enhanced standards related to claims processing, and enrollee/provider help line (call center operations);

I. Plan Selection

The Agency has selected the MMA plans through a competitive procurement with strict selection criteria. The program will provide for a limited number of plans in 11 geographic regions to ensure stability, but allow for significant recipient choice and further ensure coverage in rural areas of the state. The Agency initiated the procurement of the plans on December 28, 2012 and Notices of Intent of Award were published on September 23, 2013 and October 10, 2013. A listing of the plans selected for each region and relevant information about the procurement can be found via the Florida Department of Management Services' Vendor Bid System at: http://www.myflorida.com/apps/vbs/vbs_www.main_menu.

The Agency selected 14 standard, non-specialty MMA plans through a competitive procurement process. In addition, the Agency selected five companies to provide services to specialty populations, including specialty plans focused on HIV/AIDS, child welfare and foster care, severe and persistent mental illness, and dual eligbiles with chronic conditions. Table 3 on the following page provides a summary of the MMA plans selected in each region. The Agency anticipates executing the plan contracts in January 2014.

Remainder of page intentionally left blank.

Table 3
MMA Plans Selected by Region
([1]Plans selected as of 9/23/2013, 10/10/2013, 10/21/2013 and 10/24/13)

	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	X				X*	4
Better Health, LLC - PSN	X					X				X		3
Coventry Health Care of Florida, Inc.											X*	1
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
Molina Healthcare of Florida							X		X		X	3
Preferred Medical Plan, Inc.											X	1
Prestige Health Choice - PSN		X	X		X	X	X		X		X	7
Simply Healthcare Plans, Inc.											X	1
South Florida Community Care Network										X**		1
Sunshine State Health Plan, Inc.			X*	X*	X*	X*	X*	X*	X*	X*	X*	9
UnitedHealthcare of Florida, Inc.			X*	X*			X*				X*	4
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	4	3	4	7	6	3	4	4	10	46
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	X	9
Freedom Health, Inc. Chronic Conditions/Duals 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	3	2	4	4	4	4	4	5	5	40

* Plans (by region) also authorized as SMMC/Long-term care plans under Florida's Long-term Care Managed Care Waiver.

**Pending settlement.

[1] As October 31, 2013, the competitive procurement process used to select the MMA plans has not been finalized.

J. Plan Readiness Review Process

In October 2013, the Agency began the process of conducting a readiness review of MMA plans. The purpose of the readiness review is to assess the ability of the plans to effectively meet contractual requirements and ensure all plans are ready to conduct key operational functions by May 1, 2014, the initial date of MMA program implementation.

The Agency developed a readiness review request that all the plans must respond to in order for the Agency to complete a through desk review of identified key areas. The key areas include:

- Administration and Management
- Care Coordination/Case Management
- Claims Management
- Covered Services
- Enrollee Materials
- Enrollee Services
- Finance
- Grievance Systems
- Information Systems
- Marketing
- Prescribed Drug Services
- Program Integrity
- Provider Network
- Quality and Utilization Management

The Agency has taken advantage of the expertise of staff across the Agency to ensure the reviewers tasked with evaluating plan readiness have the knowledge and skills to complete a detailed desk review. The plans responses will not only be reviewed to ensure all contract provisions are included, but to evaluate each plan's progress in implementing key operational activities for the MMA program. The plans will also submit all documents which require Agency approval through the plan readiness review process, such as enrollee letters and marketing materials.

The Agency will use the documents provided in each plan's response to the readiness review request to gain a detailed understanding of their internal processes and operational functionality. After the desk review is complete, Agency staff will conduct an on-site review including interviews with plan staff and leadership that manage key operational areas within the plan. The Agency will also have the opportunity to request demonstrations of processes or systems crucial to a successful implementation. The on-site reviews will begin in December 2013.

After the on-site review is conducted, the Agency will compile all findings and outstanding items requiring plan action into an Implementation Action Plan. The Implementation Action Plan will outline deadlines for resolution of all outstanding items. The Agency will make a decision on whether each plan will be included in the initial implementation of the program based on the plan's response and actions taken in response to the Implementation Action Plan. The following lists the reasons the Agency would not allow a plan to be included in the initial implementation of the program.

If the Agency finds a plan has:

- An inability to timely authorize services for enrollees
- An inadequate provider network
- An inability to pay claims timely

The Agency will make a decision on which plans are ready to participate in the initial implementation of the program 60 days before each region's implementation date. Only the authorized plans will be included as options in communications about the program to potential enrollees.

K. Plan Contracting

The Agency is following standard Agency contracting procedures to enter into clear and comprehensive managed care contracts developed in accordance with all state and federal requirements. 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.

1. Contracting Assurances - Provider Network and Access Requirements

The Agency is requiring the 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.

To ensure access to necessary Medicaid services, the Agency established specific standards for the number, type and regional distribution of providers in plan networks. 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 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. The plans are required to have providers available within travel and distance standards established by the Agency. 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". The plans will be 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.

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.

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 Agency deems necessary. The provider database

must be available online to the public and allow comparison of the availability of providers to network adequacy standards, and accept and display feedback from each provider's patients.

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 to 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.

In addition, the Agency selected plans that were committed to assisting the Agency in our efforts to increase electronic medical record adoption. The plans agreed to:

- Establish thresholds for the number of physician and hospitals that would adopt meaningful use standards by the end of the second contract year.
- Establish thresholds for the number of enrollees who are assigned to primary care providers meeting meaningful use requirements.

The Agency negotiated more timely claims more timely claims process timeframes than are required by state and federal regulations. Examples include:

- Selected plans will pay, deny, or contest electronic claims within 15 calendar days.
- Selected plans will pay, deny, or contest paper claims within 20 calendar days.
- Selected plans agreed to pay 50% of all clean claims within 7 calendar days of receipt.

The Agency will conduct periodic contract oversight and monitoring reviews to ensure plan compliance with contract requirements and has developed a thorough and consistent oversight review process so that plans are held to consistent standards.

3. 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 plans 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 days 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 by law 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.

In addition to the above sanctioning capability, the Agency will sanction as a means of a financial disincentive to plans that violate contract requirements. Sanctions cover failure to meet any plan contract requirements and include sanctions for failing to meet performance measure scores (up to $10,000 for failure to meet certain performance measure group thresholds), encounter data reporting ($5,000 per day for each day of noncompliance at the 31st calendar day), fraud and abuse ($2,000 per day for failure to submit an acceptable anti-fraud plan or failure to submit the annual fraud report, $10,000 for failure to implement an anti-fraud plan or investigative unit, and $1,000 per day failure to timely report suspected or confirmed instances of provider or recipient fraud) and failure of plans, after two years of continuous operation under the new program, to pay physicians at payment rates at least equal to Medicare rates (no set sanction amount prescribed). The Agency may initiate contract termination procedures on the 90th day unless the plan comes into compliance on encounter data before that date.

The Agency may also impose liquidated damages in the event of a plan's breach of contract requirements. The plan contract allows for over 60 different liquidated damages. Damages include breaches in the following areas: staffing, failure to provide continuity of care and a seamless transition consistent with services in place prior to the new enrollee's enrollment in the plan, failure to timely complete a comprehensive assessment or timely develop a treatment or service plan or to authorize and initiate services, failure to facilitate transfers between health care settings, imposition of arbitrary utilization guidelines, reporting requirements, fraud and abuse compliance, maintenance of required insolvency protection and surplus accounts at appropriate levels, submission of timely and audited financial statements, failure to resolve problems with individual encounter records, failure to obtain Agency approval of enrollee and provider materials, non-submission of performance improvement plans, compliance with community outreach and marketing requirements, notice of action failures and other enrollee notification failures, medical and behavioral health network adequacy failures. The liquidated damages range from $250 per occurrence (failure to certify reports correctly) to $25,000 per occurrence (example – imposition of arbitrary utilization guidelines).

Remainder of page intentionally left blank.

Appendix I
Implementation Activities – October 2013

IMPLEMENTATION ACTIVITIES	
1. Plan Selection	**Objective:** The Agency will develop a plan selection process to ensure contracting with high quality plans that have experience serving the Medicaid population. **Status:** Completed 1.1 Develop procurement evaluation plan. 1.2 Issue MMA Invitation to Negotiate (ITN). 1.3 Appoint and train evaluation team/negotiators. 1.4 Receive MMA bids from potential managed care plans. 1.5 Evaluate plan proposals for mandatory requirements. 1.6 Solicit and evaluate provider input of potential managed care plans. 1.7 Review and evaluate the responses to the MMA ITN with particular attention to the plans' past performance in the provision of health care services and quality improvement. 1.8 Select plans for negotiation and finalize rates in negotiations with plans. 1.9 Select plans and posted MMA awards on Florida's designated procurement site.
2. Comprehensive Outreach and Education	**Objective:** The Agency will develop and continue to refine a comprehensive outreach and education program to facilitate a smooth transition to the MMA program by ensuring all affected recipients, providers and all stakeholders are informed of changes and the potential impact. **Status:** In Progress 2.1 Develop recipient outreach and education plan. 2.2 Develop provider outreach and education plan. 2.3 Conduct public meetings and workshops for recipients and advocacy groups. 2.4 Conduct public meetings, workshops and webinars for providers. 2.5 Make information available on the Agency's Website, where official documents and updates are posted. 2.6 Publish public notices to announce meetings/workshops to provide updates and obtain public input on the implementation of the MMA program.
3. Plan Readiness Review	**Objective:** The Agency will develop plan readiness review process and procedures that will ensure the MMA plans are capable of fulfilling all state and federal requirements. **Status:** Completed 3.1-3.2; In Progress 3.3-3.15

IMPLEMENTATION ACTIVITIES	
	3.1 Review the current process and procedures utilized in plan readiness processes. 3.2 Develop plan readiness processes and tools to be utilized with the implementation of the program. 3.3 Appoint readiness review teams and schedule reviews for each region by the staggered implementation timeline. 3.4 Conduct any follow-up financial review and approval. 3.5 Conduct any follow-up organizational and administration review and approval. 3.6 Conduct quality review and approval of policies and procedures. 3.7 Conduct member and provider correspondence review and approval. 3.8 Conduct conductivity testing and file transfer between Agency and plans. 3.9 Review MMA plans' provider credentialing process and conduct provider network review and approval (includes provider, subcontractor, facility, etc.). 3.10 Review MMA plans' Board of Directors/committee meeting minutes and conduct staff interviews. 3.11 Review MMA plans' fraud and abuse program. 3.12 Review MMA plans' staff training plan and schedule. 3.13 Review MMA plans' provider training manual, training schedule, monitoring plan, and schedule. 3.14 Review MMA plans' list of all delegated services and pre-delegation audit reports of those services. 3.15 Complete on-site operational review and review MMA plans' demonstrations of various systems (enrollment/disenrollment, member services, claims processing, report production, case management/care coordination, utilization management, quality improvement, etc.).[2]
4. Contract Execution	**Objective:** The Agency will execute contracts with selected managed care plans capable of fulfilling all state and federal requirements. **Status:** In Progress 4.1 Finalize contracts and negotiation agreements. 4.2 Appoint and train designated contract managers. 4.3 Route contracts for signature with the selected MMA plans. 4.4 Record final contract copies with signatures from plans and the Agency. 4.5 Ensure policy and compliance offices have copies of executed contracts. 4.6 Submit certification of actuarially sound rates to the Centers for Medicare and Medicaid Services. 4.7 Submit executed contracts to the Centers for Medicare and Medicaid Services. 4.8 Perform administrative functions to close initial contract process. 4.9 Perform administrative functions to set up FLMMIS provider files. 4.10 Post model contract, plan information and related documents on the Agency's Website.

[2] The elements outlined above are not all-inclusive and additional information may be requested at any time during the readiness review process.

IMPLEMENTATION ACTIVITIES	
5. Recipient Enrollment	**Objective:** The Agency will implement the enrollment process. The Agency assures that information to potential MMA enrollees will meet requirements under Section 1932(a)(5), Provision of Information. **Status:** In Progress 5.1; Not Started 5.2 – 5.11 5.1 Develop and test auto-assignment algorithm. 5.2 Operationalize toll-free hotline with interpretation services, bilingual and multilingual staff, usage of a standardized telephone script and Automated Voice Response System, call monitoring, distribution, scheduling and reporting software, face-to-face and online enrollment processes. 5.3 Notify recipients of their new options for MMA plan enrollment. 5.4 Initiate choice counseling call center and online enrollment application process. 5.5 Mail recipient letters regarding participation in MMA program and 30-day choice period. 5.6 Send confirmation letters for enrollees who select a plan 30 days prior to transition date. 5.7 Send notification letters to affected enrollees not selecting a plan 30 days prior to transition date. 5.8 Process self-selection enrollments through the choice counselor effective the next possible month according to the Agency's monthly processing cycle. 5.9 Process auto-assignment for mandatory recipients who have not selected a plan to be effective the next possible month after the 30th calendar day following the date on the mandatory new eligible letter/auto-assignment letter, according to the Agency's monthly processing cycle. 5.10 Process plan change and disenrollment requests from verified callers, including processing "For Cause" or "Good Cause" changes in accordance with 42 CFR 438.56. 5.11 Process plan change within 90 days after enrollment for selection of another plan without cause.
6. Transition Process and Plan Monitoring	**Objective:** The Agency will implement a transition and monitoring process to ensure continuity of care for recipients transitioning into MMA plans. **Status:** In Progress 6.1 – 6.2; Not Started 6.3 – 6.13 6.1 Analyze existing plans to identify enrollees' primary care providers to facilitate transition into the MMA plans. 6.2 Assist primary care providers (PCPs) unique to existing plans through the Medicaid provider registration process to facilitate an existing PCP's enrollment in MMA plan networks. 6.3 Implement transition plans, including review of provider networks to assess availability of network providers within each region and each plan, for recipients enrolled in the existing programs: 6.4 Develop and implement operational transition plan for Agency staff to ensure staff will: - Assess capacity of plans. - Coordinate with choice counseling to ensure appropriate and timely notice of plan choice. - Coordinate with plans to ensure existing provider relationships are maintained as possible.

IMPLEMENTATION ACTIVITIES	
	- Determine whether each recipient has received services from one of the plans' PCP. 6.5 Establish protocols with MMA plans and stakeholders to ensure appropriate feedback from impacted enrollees and providers to help ensure understanding of program changes. 6.6 Conduct regular calls with Agency staff and enrollment broker to resolved issues in a timely manner. 6.7 Issue program guidance, provider alerts and recipient communication as required to address identified issues. 6.8 Develop schedule for initial monitoring including on-site surveys and desk reviews. 6.9 Distribute the self-assessment checklists to the plans for use. 6.10 Collect and analyze plans' self-assessment checklists. 6.11 Conduct initial desk reviews and on-site surveys. 6.12 Develop schedule for ongoing monitoring including on-site surveys and desk reviews. 6.13 Conduct initial desk reviews and on-site surveys.

Appendix II Draft Comprehensive Outreach Schedule

Timeline	October *2013*				November *2013*				December *2013*			
GO LIVE DATE												
Weeks	10/7-10/11	10/14 - 10/18	10/21-10/25	10/28-10/31	11/1 - 11/8	11/11 - 11/15	11/18 - 11/22	11/25 - 11/29	12/2 - 12/6	12/9 - 12/13	12/16 - 12/20	12/23 - 12/31
Target Outreach Group												
General Public	UPDATE!				UPDATE!				UPDATE!			
Legislature												
Media												
AHCA Staff												
Beneficiaries												
Standard Recipients												
Special Populations												
Providers												
MMA Plans												
MMA Network Providers												
MMA Provider Associations												
All Other Stakeholders												

Outreach Tool Key:

PowerPoint / Presentation		Webinar		TV		Radio		Calls		Press Release		
Mail / Letter		Email		Facebook		Twitter		In Person		Newspapers		
YouTube		Website Update	UPDATE!									

October 2013

Date Weekly:	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
Week of 10/7/2013				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC Website.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
Week of 10/14/2013				
	AHCA Staff	Executive Management	PowerPoint	Monthly AHCA Staff update on SMMC.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
Week of 10/21/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
Week of 10/28/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.

November 2013

Date Weekly:	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
Week of 11/1/2013				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC Website.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/ Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and Frequently Asked Questions (FAQs).
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
Week of 11/11/2013				
	AHCA Staff	Executive Management	PowerPoint	Monthly AHCA Staff update on SMMC.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/ Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
Week of 11/18/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/ Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
Week of 11/25/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/ Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.

December 2013

Date	Target Outreach Group	Outreach Conducted By	Outreach Tool Used	Notes: Additional Detail
Week of 12/2/2013				
	General Public	Outreach Team	Website Update	Monthly meetings to update SMMC Website.
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/ Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
Week of 12/9/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Providers/Beneficiaries/Stakeholders/ Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	AHCA Staff	Executive Management	PowerPoint	Monthly AHCA Staff update on SMMC.
Week of 12/16/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/ Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.
Week of 12/23/2013				
	Plans	Readiness Team	Phone	Weekly call to provide additional assistance and instruction and allow for Q&A.
	Plans	Readiness Team	Phone	Weekly Technical Assistance Calls with the Plans.
	Providers/Beneficiaries/Stakeholders/ Special Populations	Outreach Team	Webinar	Weekly Webinars to provide program information and FAQs.

State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

2727 Mahan Drive
Tallahassee, FL 32308
ahca.myflorida.com

Mission Statement
Better Healthcare for All Floridians.