

**WAIVERS AND AUTHORITIES FOR FLORIDA'S
MEDICAID REFORM SECTION 1115 DEMONSTRATION**

NUMBER: 11-W-00206/4

TITLE: Florida Medicaid Reform Section 1115 Demonstration

AWARDEE: Agency for Health Care Administration

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

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

Title XIX Waivers

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

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

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

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits. Also this waiver is to permit Florida to offer different benefits to Demonstration Population A than to the categorically needy group.

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

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

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

To enable Florida to require mandatory enrollment into managed care plans with restricted networks of providers.

**EXPENDITURE AUTHORITY
FOR FLORIDA'S MEDICAID REFORM
SECTION 1115 DEMONSTRATION**

NUMBER: 11-W-00206/4

TITLE: Florida Medicaid Reform Section 1115 Demonstration

AWARDEE: Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this Demonstration December 16, 2011, through June 30, 2014, be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable Florida to operate the Florida Medicaid Reform section 1115 Demonstration.

- 1. Demonstration Population A.** Expenditures for health care related costs under enhanced benefit accounts for individuals who lose eligibility for Medicaid or Demonstration Population A benefits. This expansion population shall be allowed to retain access to the enhanced benefits account for up to 1 year, except in the instance of termination of the Demonstration or the enhanced benefits account provision under the Demonstration.
- 2.** Expenditures for costs incurred as a result of the automatic re-enrollment, in the last plan of enrollment, for enrollees who have regained eligibility within six months, and which would not otherwise be eligible for automatic re-enrollment under Section 1903(m)(2)(H) of the Act.
- 3.** Expenditures made by Florida for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, subject to the restrictions placed on the Low Income Pool, as defined in the STCs.
- 4.** Expenditures for benefits under the enhanced benefits account program.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

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

1. Provision of Medical Assistance

Section 1902(a)(10)(A)

To enable Florida to limit the medical assistance for Demonstration Population A to the types of assistance described in these expenditure authorities.

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

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

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00206/4**

TITLE: **Medicaid Reform Section 1115 Demonstration**

AWARDEE: **Agency for Health Care Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Medicaid Reform section 1115(a) Demonstration (hereinafter “Demonstration”). The parties to this agreement are the Agency for Health Care Administration (Florida) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State’s obligations to CMS during the life of the Demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The effective date of the Demonstration is December 16, 2011, and is approved through June 30, 2014.

The STCs have been arranged into the following subject areas:

- I. Preface;
- II. Program Description and Objectives;
- III. General Program Requirements;
- IV. General Reporting Requirements;
- V. Florida Reform Implementation;
- VI. Eligibility;
- VII. Enrollment;
- VIII. Choice Counseling;
- IX. Benefit Packages and Medicaid Reform Plans;
- X. Enhanced Benefits Account Program;
- XI. Cost Sharing;
- XII. Delivery Systems;
- XIII. Low Income Pool;
- XIV. Low Income Pool Milestones;
- XV. General Financial Requirements;
- XVI. Monitoring Budget Neutrality;
- XVII. Evaluation of the Demonstration; and,
- XVIII. Schedule of State Deliverables.

Additionally, one attachment has been included to provide supplementary guidance.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Florida Medicaid Reform Demonstration was approved October 19, 2005. The State implemented the Demonstration July 1, 2006, in Broward and Duval Counties, and then expanded to Baker, Clay, and Nassau Counties July 1, 2007.

Under the Demonstration, most Medicaid eligibles are required to enroll in a managed care plan (either a capitated health plan or a fee-for-service Provider Service Network plan) as a condition for receiving Medicaid. Participation is mandatory for TANF related populations and the aged and disabled with some exceptions. The Demonstration allows plans to offer customized benefit packages and reduced cost-sharing, although each plan must cover all mandatory services, and all State plan services for children and pregnant women (including EPSDT). The Demonstration provides incentives for healthy behaviors by offering Enhanced Benefits Accounts and established a Low Income Pool (LIP) to ensure continued support for the provision of health care services to Medicaid, underinsured and uninsured populations.

The fundamental elements of Florida Medicaid Reform are as follows:

Risk-Adjusted Premiums pay Medicaid Reform capitated plans monthly premiums that are adjusted to reflect the health status of plan's beneficiaries and are actuarially equivalent to all services covered under the current Florida Medicaid program.

Enhanced Benefits Accounts provide incentives to Medicaid Reform enrollees for healthy behaviors. Enrollees who participate in these activities earn credits that can be used for health care related expenditures such as over-the-counter pharmaceuticals and vitamins.

Low Income Pool (LIP) funds provide direct payment and distributions to safety net providers in the State for the purpose of defraying some of the uncompensated costs these providers incur in furnishing services to the uninsured and underinsured populations. The LIP is also designed to support programs that enhance the quality of care and the health of low income populations.

Under the Demonstration, Florida seeks to continue building on the following objectives:

- Introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost;
- Increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service program;
- Improve health outcomes and reduce inappropriate utilization;
- Demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve;
- Serve as an effective deterrent against fraud and abuse by moving from a fee-for-service to a managed care delivery system;
- Maintain strict oversight of managed care plans including adapting fraud efforts to surveillance of fraud and abuse within the managed care system;
- Provide managed care plans with flexibility in creating benefit packages to meet the

- needs of specific groups; and,
- Provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid Program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents, of which these terms and conditions are part, must apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**
 - a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b) If mandated changes in the Federal law, regulation, or policy requires State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit a title XIX State plan amendment for changes to any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the State plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, LIP, Federal financial participation (FFP), sources of non-Federal share of funding, budget neutrality, and other comparable program and budget elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7, below.

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 well 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;

 - 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.

8. **Enhanced Benefits Account Program Phase Out.** The State shall submit a phase-out plan to CMS for approval no later than 6 months prior to any such time the State proposes to terminate the Enhanced Benefits Account Program (EBAP) provision of this Demonstration. The EBAP will be limited as follows:
 - a) Enrollees will not be able to earn credits for enhanced benefits for deposit into their account during the last 3 months of the Demonstration or the termination of the EBAP Provision under the Demonstration; and

- b) Individuals, who previously earned credits for enhanced benefits in their account, will continue to have access to funds for health care related expenditures in accordance with EBAP rules (see paragraph 51).
9. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
10. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.
11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
12. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) unless they are otherwise superseded by rules promulgated by CMS. The State must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and/or renewal of this Demonstration.
14. **Managed Care Requirements.** The State must comply with the managed care regulations published at 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan services used in the rate development process.

The State must provide for the following:

Demonstration Approval Period: December 16, 2011 – June 30, 2014

- a) Policies to ensure an increased stability among managed care organizations (MCO) and provider service networks (PSNs) and minimize plan turnover. This could include a limit on the number of participating plans in the five Demonstration counties. Plan selection and oversight criteria should include: confirmation that solvency requirements are being met; an evaluation of prior business operations in the State; and financial penalties for not completing a contract term. The State must report quarterly on the plans entering and leaving Demonstration counties, including the reasons for plans leaving. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension;
- b) Requirements contained herein are intended to be consistent with and not additional to the requirements of 42 CFR 438. Policies to ensure network adequacy and access requirements which address travel time and distance, as well as the availability of routine, urgent and emergent appointments, and which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The State must implement a thorough and consistent oversight review for determining plan compliance with these requirements and report these findings to CMS on a quarterly basis. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension;
- c) A requirement that each MCO and capitated PSN maintain an annual Medical Loss Ratio (MLR) of 85 percent for Medicaid operations in the Demonstration counties and provide documentation to the State and CMS to show ongoing compliance. The State must develop quarterly reporting of MLR during Demonstration year (DY) 6 specific to Demonstration counties. Beginning in DY 7 (July 1, 2012), plans must meet annual MLR requirements. CMS will determine the corrective action for non-compliance with this requirement;
- d) Policies that provide for an improved transition and continuity of care when enrollees are required to change plans (e.g. transition of enrollees under case management and those with complex medication needs, and maintaining existing care relationships). Policies must also address beneficiary continuity and coordination of care when a physician leaves a health plan and requests by beneficiaries to seek out of network care. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension; and,
- e) Policies to ensure adequate choice when there are fewer than two plans in any rural county, including contracting on a regional basis where appropriate to assure access to physicians, facilities, and services. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension.

IV. GENERAL REPORTING REQUIREMENTS

- 15. **General Financial Requirements.** The State must comply with all general financial requirements set forth in Section XV.

16. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements set forth in Section XVI.
17. **Managed Care Data Requirements.** All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438. Encounter data requirements shall include the following:
 - a) Encounter Data – All managed care organizations in the Demonstration shall be responsible for the collection of all data on services furnished to enrollees through encounter data or other methods as specified by the State, and the maintenance of these data at the plan level. The State shall, in addition, develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all inpatient hospital and physician services), as well as a process to validate that each plan’s encounter data are timely, complete and accurate. The State will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The State shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion.
 - b) Encounter Data Validation Study for New MCOs - If the State contracts with new managed care organizations, the State shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of Demonstration enrollees.
 - c) Submission of Encounter Data - The State shall submit encounter data to the Medicaid Statistical Information System (MSIS) as is consistent with Federal law. The State must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the State.
18. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include but are not limited to, MCO operations (such as contract amendments, rate certifications, plans withdrawing or entering the Demonstration), health care delivery, enrollment, quality of care, access, benefit packages, the Enhanced Benefits Account Program, choice counseling activities, audits, lawsuits, financial reporting related to budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting that impact the Demonstration. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

19. **Quarterly Reports.** The State must submit progress reports, to include the items outlined below (see also Attachment A), no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:
- a) An updated budget neutrality monitoring spreadsheet including enrollment data, member month data, and expenditure data in the format provided by CMS;
 - b) A discussion of events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, including but not limited to: approval and contracting with new plans; geographic expansion; benefits; enrollment and disenrollment; grievances; quality of care; access; pertinent legislative or litigation activity; and other operational issues;
 - c) Action plans for addressing any policy, administrative, or budget issues identified;
 - d) State efforts related to the collection and verification of encounter data, and utilization data;
 - e) Medical Loss Ratio data pertaining to Medicaid plan operations in Demonstration counties;
 - f) Enrollment data disaggregated by plan and by the following specifications: eligibility category, TANF and SSI, total number of enrollees; market share; and percentage change in enrollment by plan. In addition, the State will provide a summary of voluntary and mandatory selection rates and disenrollment data;
 - g) Choice of plans and capacity of plans participating in the Reform counties;
 - h) Low Income Pool activities and associated expenditures;
 - i) Activities related to choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups;
 - j) Participation rates in the Enhanced Benefits Account Program. This shall include: participation levels; summary of activities and the associated expenditures; number of accounts established including active participants and individuals who continue to retain access to funds in an account but no longer actively participate; estimated quarterly deposits in accounts, and expenditures from the account;
 - k) Status of managed care plan performance, initiatives and activities, as measured by HEDIS, CAHPs and other quality metrics;
 - l) Progress toward the Demonstration goals; and,
 - m) Evaluation activities.
20. **Annual Report.** The State must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly reports required under paragraph 19 and include a section that provides qualitative and quantitative data that describes the impact the LIP has had on the rate of uninsurance in Florida since implementation of the Demonstration. The State must submit this report no later than 120 days after the close of each DY.
21. **Transition Plan.** The State is required to prepare and incrementally revise, a Transition

Plan consistent with the provisions of the Affordable Care Act (ACA) for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The State must submit a draft final report to CMS by July 1, 2012, with progress updates included in each quarterly report required by paragraph 19.

V. FLORIDA REFORM IMPLEMENTATION

22. **Reform Implementation.** Counties where Reform is implemented will be known as Reform Counties. The State must request an amendment to the Demonstration, as described in paragraphs 6 and 7, should the State desire to expand the Demonstration to additional Florida counties or mandate enrollment into the Demonstration for populations that are not required to be mandatorily enrolled in the Demonstration as of December 5, 2011. The following is a list of Reform Counties:
- a) Baker, Broward, Clay, Duval, and Nassau Counties (as of June 30, 2011); and,
 - b) Other counties which the State may designate as Reform Counties by obtaining CMS approval of a Demonstration amendment.

VI. ELIGIBILITY

23. **Consistency with State Plan Eligibility Criteria.** There is no eligibility expansion or reduction under this Demonstration except that individuals who lose Medicaid eligibility will continue for a period of one-year to have access to benefits accrued in their name under the EBAP.
24. **Participation in the Reform Demonstration.** Reform Participants are individuals eligible under the approved State plan who reside in Reform Counties who are described below as “mandatory participants” or as “voluntary participants”. Mandatory participants are required to enroll in a MCO or PSN as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a Demonstration MCO or PSN to receive Medicaid benefits.
- a) Mandatory Participants - Individuals who reside in Reform Counties and who belong to the categories of Medicaid eligibles listed in the following table and who are not listed as excluded from mandatory participation are required to be Reform Participants.

Mandatory State Plan Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Demonstration Population (See STC 64)
Infants under age 1	Up to 150 % of the Federal Poverty Level (FPL)	Population 7
Children 1-5	Up to 133% of the FPL	Population 7
Children 6-18	Up to 100% of the FPL	Population 7
Blind/Disabled Children	Children eligible under SSI	Population 1
TANF Pregnant women	Up to AFDC Income Level (Families whose	Population 7

	income is below the TANF limit – 20% of the FPL or \$303 per month for a family of 3, with assets less than \$2,000.	
Section 1931 adults	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or \$303 per month for a family of 3, with assets less than \$2,000.	Population 7
Aged/Disabled Adults	Persons receiving SSI whose eligibility is determined by SSA	Population 1
Optional State Plan Groups		
Infants under age 1 (Title XIX funded)	151% up to 185% of the FPL	Population 7

Note: Mandatory enrollment into the Children’s Medical Services Specialty Plan is required for children residing in Broward and Duval Counties with special health care needs who meet clinical eligibility screening requirements.

b) Voluntary Participants – The following individuals are excluded from mandatory participation under subparagraph (a) but may choose to be voluntary participants in the Reform Demonstration:

- i. Foster care children;
- ii. Individuals with developmental disabilities;
- iii. Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD;
- iv. Individuals receiving hospice services;
- v. Pregnant women with incomes above the 1931 poverty level;
- vi. Dual eligible individuals;
- vii. Medikids under title XXI; and,
- viii. Children under age 1 with family income 186% - 200% of the FPL under title XXI.

c) Excluded From Reform Participation - The following groups of Medicaid eligibles are excluded from participation in the Demonstration.

- i. Individuals whose immigration status is as a refugee eligible;
- ii. Individuals eligible as medically needy;
- iii. Individuals residing in State mental facilities (over age 65);
- iv. Family planning waiver eligibles; and,
- v. Individuals eligible as women with breast or cervical cancer.

25. **Expansion Population for the Continuation of the EBAP.** Individuals who lose eligibility for Medicaid will continue to have limited eligibility under this Demonstration for a period of one year. This population retains eligibility under the Demonstration solely to access accrued funds in their individual enhanced benefits account for a period of one year, except in the instance of termination of the Demonstration or the EBAP. These individuals will receive no other benefits than those available through the EBAP. This population is limited to individuals who have accrued

funds in an individual enhanced benefit account. These individuals are identified as Demonstration Population A.

VII. ENROLLMENT

This section describes enrollment provisions that are applicable to Medicaid eligible individuals living in Florida counties in which the Reform Demonstration has been implemented.

26. **New Reform Demonstration Enrollees.** At the time of eligibility determination, individuals who are mandated to participate must receive information about managed care plan choices in their area. They must be informed of their options in selecting an authorized managed care plan. Individuals must be provided the opportunity to meet or speak with a choice counselor to obtain additional information in making a choice. New enrollees will be required to select a plan within 30 days of eligibility determination. If the individual does not select a plan within the 30-day period, the State may auto-assign the individual into a Medicaid Reform Plan or a PSN. Once individuals have made their choice, they will be able to contact the State or the State's designated choice counselor to register their plan selection.

27. **Auto-Enrollment Criteria.** Each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the choice counselor will provide information to the individuals to encourage an active selection. Enrollees who fail to choose within this timeframe will be auto-assigned to a managed care plan. At a minimum, the State will use the criteria listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the State will make enrollee assignments consecutively by family unit. The criteria includes but is not limited to:
 - a) A managed care plan has sufficient provider network capacity to meet the needs of enrollees;
 - b) The managed care plan has previously enrolled the enrollee as a member, or one of the plan's primary care providers has previously provided health care to the enrollee;
 - c) The State has knowledge that the enrollee has previously expressed a preference for a particular managed care plan as indicated by Medicaid fee-for-service claims data, but has failed to make a choice; and,
 - d) The managed care plan's primary care providers are geographically accessible to the recipient's residence.

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

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

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

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

VIII. CHOICE COUNSELING

30. **Choice Counseling Defined.** The State shall contract for choice counselor services to provide full and complete information about managed care plans choices. The State will ensure a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.
31. **Choice-Counseling Materials.** Through the choice counselor the State offers an extensive enrollee education and rating system so individuals will fully understand their choices and be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly.
32. **Choice Counseling Information.** The State or the State's administrator provides information on selecting a Reform plan. The State or the State's designated choice counselor provides information about each plan's coverage in accordance with Federal requirements. Information includes but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, contact information,

performance measures, results of consumer satisfaction reviews, and data on access to preventive services. In addition, the State may supplement coverage information by providing performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data.

33. **Delivery of Choice Counseling Materials.** Choice counseling materials will be provided in a variety of ways including the internet, print, telephone, and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY.
34. **Contacting the Choice Counselor.** Individuals contact the State or the State's designated choice counselor to obtain additional information. Choice counseling and enrollment information is available at the AHCA website or by phone. The State or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees. The State must ensure mechanisms are in place to monitor and evaluate choice counseling call center metrics and the individual performance of choice counseling personnel.

IX. BENEFIT PACKAGES & MEDICAID REFORM PLANS

35. **Customized Benefit Packages for Medicaid Reform.** Capitated plans will have the flexibility to provide customized benefit packages for Demonstration enrollees. PSNs operating under fee-for-service must provide all benefits for all enrolled beneficiaries as are available under the State plan. The customized benefit packages must include all State plan services otherwise available under the State plan for pregnant women and children including all EPSDT services for children under age 21. The customized benefit packages must include all mandatory services specified in the State plan for all populations. The amount, duration and scope of optional services, may vary to reflect the needs of the plan's target population and plans can offer additional services and benefits not available under the State plan. The plans authorized by the State shall not have service limits more restrictive than authorized in the State Plan for children under the age of 21, pregnant women, and emergency services. The State may also capitate all State Plan services for Demonstration enrollees.
36. **Overall Standards for Customized Benefit Packages.** All benefit packages must be prior-approved by the State and must be at least actuarially equivalent to the services provided to the target population under the current State Plan benefit package. In addition the plan's customized benefit package must meet a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population.
37. **Plan Evaluation Tool.** The State will utilize a Plan Evaluation Tool (PET) to determine if a plan that is applying for a Medicaid Reform Plan contract meets State

requirements. The PET measures for actuarial equivalency and sufficiency. Specifically, it 1) compares the value of the level of benefits (actuarial equivalency) in the proposed package to the value of the current State Plan package for the average member of the population and 2) ensures that the overall level (sufficiency) of certain benefits is adequate to cover the vast majority of enrollees. The State will evaluate service utilization on an annual basis and use this information to update the PET to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

38. **Plan Evaluation Tool: Actuarial Equivalency.** Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid State Plan services. This process ensures that the expected claim cost levels of all Reform plans are equal (using a common benchmark reimbursement structure) to the level of the historic fee-for-service plan for the target population and its historic levels of utilization. The State uses this as the first threshold to evaluate the customized benefit package submitted by a plan to ensure that the package earns the premium established by the State. In assessing actuarial equivalency, the PET considers the following components of the benefit package: services covered; cost sharing; and additional benefits offered, if any. Additional services offered by the plan will be considered a component of the plan's customized benefits and not a component of the Enhanced Benefit Plan.
39. **Plan Evaluation Tool: Sufficiency.** In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet or exceed, and maintain, a minimum threshold of 98.5 percent for benefits identified as sufficiency tested benefits. The sufficiency test provides a safeguard when plans elect to vary the amount, duration and scope of certain services. This standard is based on the target population's historic use of the applicable Medicaid State Plan services (e.g. outpatient hospital services, outpatient pharmacy prescriptions) identified by the State as sufficiency tested benefits. Each proposed benefit plan must be evaluated against the sufficiency standard to ensure that the proposed benefits are adequate to cover the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for the target population that is expected to exceed the plan's proposed benefit level.

X. ENHANCED BENEFITS ACCOUNT PROGRAM

40. **Enhanced Benefits Account Program Defined.** The EBAP provides incentives to Medicaid Reform enrollees for participating in State defined activities that promote healthy behaviors. An individual who participates in a State defined activity that promotes healthy behaviors earns credits that are posted to an individual's account. Earned credits may be used for health care related expenditures as approved under the EBAP and defined in Section 1905 of the Act.
41. **Administration Overview.** The State will maintain a list of activities that generate contributions to the account. A menu of benefits or programs will be provided as will the individual value of each item on the menu. The amount available to individuals

from their enhanced benefit account will depend on the activities in which they participate up to a maximum amount. Once an enrollee completes an approved activity, the enrollee will be considered an active participant. The State will post earned credits into an account for use by the enrollee. Additional credits may be earned as the enrollee participates in additional activities. In no instance will the individual receive cash.

42. **Participants Earning Enhanced Benefits Accounts Defined.** All enrollees in a Reform plan, including mandatory and voluntary enrollees, will be eligible to participate in activities to earn enhanced benefits for the duration of their enrollment. The exception to this provision is at the time of EBAP phase out as discussed in Section III, “General Program Requirements”.
43. **Participant Access to Credits.** The State will provide access to an individual’s earned credits in an enhanced benefit account as follows:
 - a) Individuals who are enrolled in a Reform plan and who have participated in a State defined activity that promotes healthy behavior and thus have a positive balance;
 - b) Individuals who no longer are enrolled in a Reform plan (either due to loss of eligibility or change of eligibility to an eligibility group not authorized to participate) but who have a positive balance in their account;
 - c) Regardless of the reason for the loss of eligibility to participate in the Demonstration, an individual may retain access to any earned funds for a maximum of one year, except in the instance of termination of the Demonstration or the EBAP; and,
 - d) If an individual subsequently regains Medicaid eligibility, the enrollee will be eligible to participate in the EBAP and earn additional credits.
44. **Federal Financial Participation (FFP).** The State shall claim FFP at the time the enhanced benefits credits are utilized by an enrollee to purchase an approved product, supply, or service.
45. **Enhanced Benefits Account Program Contracts.** The State shall provide CMS a copy of any procurement document to administer the EBAP. In addition, the State will provide the CMS Regional Office a copy of the contract for approval, to administer the EBAP. At a minimum, the contract will specify the scope of work, duration of the contract, and the amount of contract.
46. **Effective and Efficient Administration.** The State will submit documentation related to EBAP eligibility activities, respective earnings for each activity, eligible health related expenditures and access to account information in the Annual Report and Quarterly Reports as discussed in Section IV.

XI. COST SHARING

47. **Premiums and Co-Payments.** The State must pre-approve all cost sharing allowed by Reform plans. Cost-sharing must be consistent with the State Plan except that Reform plans may elect to assess cost sharing that is less than what is allowed under the State plan.

XII. DELIVERY SYSTEMS

48. **Health Plans.** The MCOs and capitated PSNs must be authorized by State Statute and must adhere to 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438. The certification shall identify historical utilization of State plan services used in the rate development process. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS Regional Office approval prior to implementation.
- a) Managed Care Organization MCO – An entity that meets the requirements as described in 42 CFR 438.2.
 - b) Provider Service Network (PSN) – An entity established or organized by a health care provider or group of affiliated health care providers that meet the requirements of Florida Statutes. A PSN may be reimbursed on a fee-for-service or capitated basis as specified in State statute.
49. **Freedom of Choice.** An enrollee’s Freedom of choice of providers shall be limited to and through whom individuals may seek services, including the EBAP for populations enrolled in the Florida Medicaid Reform Demonstration. The State must provide Demonstration enrollees access to the MediPass or fee-for-service delivery systems as necessary to meet the choice requirements as under 42 CFR 438.52 and 42 CFR 438.56.
50. **Evaluation of Plan Benefits.** The State will review and update the PET for assessing a plan’s benefit structure to ensure actuarial equivalence and that services are sufficient to meet the needs of enrollees in the Medicaid Reform area. At a minimum, the State must conduct the review and update on an annual basis. The State will provide CMS with 60-days advance notice and a copy of any proposed changes to the PET.

XIII. LOW INCOME POOL

51. **Low Income Pool Definition.** The LIP provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS’ Three-Part Aim as described in paragraph 61(a). The LIP consists of a capped annual allotment of \$1 billion total computable for each year of the Demonstration extension.

52. **Availability of Low Income Pool Funds.** Funds in the LIP are available to the State on an annual basis subject to any penalties that are assessed by CMS for the failure to meet milestones as discussed in Section XV “Low Income Pool Milestones”. Funds available through the LIP may be reduced to recoup payments made to providers that are determined by CMS to have been made in excess of allowable costs. Any necessary recoupments will be achieved through a reduction of FFP claimed against current LIP payments. Available funds not distributed in a DY may be rolled over to the next DY. All LIP funds must be expended by June 30, 2014. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the State and not recoverable.
53. **LIP Reimbursement and Funding Methodology.** LIP permissible expenditures defining State authorized expenditures from and entities eligible to receive LIP reimbursement are defined in the Reimbursement and Funding Methodology document dated June 26, 2009. This document limits LIP payments to allowable costs incurred by providers and requires the State to reconcile LIP payments to auditable costs. CMS is currently working with the State on reconciliations for DY 1, 2, and 3. Reconciliations for DY 4 and 5 are not yet available. CMS and the State will finalize DY 1, 2, and 3 reconciliations within 60 days of the acceptance of these STCs. The State must submit the LIP reconciliations for DY 4 to CMS by May 31, 2012 and the reconciliations for DY 5 by May 31, 2013. The DY 4 and DY 5 reconciliations (required by May 31st of the respective year) may include “as filed cost report data” but will be considered the final reconciliation.

If the reconciliations for DY 1, 2, and 3 identify LIP payments in excess of allowable cost consistent with paragraph 54 and the Reimbursement and Funding Methodology document implementing the LIP, the State must modify the Reimbursement and Funding Methodology applicable to DY 6 to ensure that payments under the LIP are consistent with the LIP goals and that providers will not receive payments that exceed their costs utilizing the cost reconciliation information to inform payment methodology modifications. CMS will also work with the State to identify modifications to the Methodology to address any cost documentation or audit processes necessary to fully meet cost reconciliation requirements. Any changes required by CMS will be applied prospectively to payments and audits for DY 6. The State may claim LIP payments based on the existing Methodology during the 60 day reconciliation finalization period. Claims after that period can only be made on the modified final Reimbursement and Funding Methodology approved by March 1, 2012. Changes to the Reimbursement and Funding Methodology document requested by the State must be approved by CMS and are only approved for DY 6 LIP expenditures.

DY 4 reconciliation results will be reflected in the Reimbursement and Funding Methodology document for DY 7. If the final reconciliations for DY 4 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in DY 7 will not result in payments in excess of allowable cost, particularly methodologies that provide payments to providers that have received payments during any prior demonstration year in excess of allowable costs as defined in paragraph 54 and the Reimbursement and

Funding Methodology. Any required modifications to the DY 7 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for DY 7 LIP payments.

DY 5 reconciliation results will be reflected in the Reimbursement and Funding Methodology document for DY 8. If the final reconciliations for DY 5 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in DY 8 will not result in payments in excess of allowable cost, particularly methodologies that provide payments to providers that have received payments during any prior demonstration year in excess of allowable costs as defined in paragraph 54 and the Reimbursement and Funding Methodology. Any required modifications to the DY 8 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for DY 8 LIP payments.

The State shall by February 1, 2012 and each successive February 1st of the renewal period, submit a protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP as described in paragraph 51 and that providers receiving LIP payments do not receive payments in excess of their cost of providing services. FFP is not available for LIP payments until the protocol is finalized and approved by CMS.

54. **Low Income Pool Permissible Expenditures.** Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care costs may be incurred by the State, by hospitals, clinics, or by other provider types to furnish medical care for the uninsured and underinsured for which compensation is not available from other payors, including other Federal or State programs. Such costs may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS. These health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments).
55. **Low Income Pool Expenditures - Non-Qualified Aliens.** LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens.
56. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such

expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in paragraph 53.

57. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid at cost and are further defined in the Reimbursement and Funding Methodology document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.
58. **Low Income Pool Permissible Non-Hospital Based Expenditures.** To ensure services are paid at cost, the Reimbursement and Funding Methodology document defines the cost reporting strategies required to support non-hospital based LIP expenditures.
59. **Permissible Sources of Funding Criteria.** Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes) shall be impermissible.

XIV. LOW INCOME POOL MILESTONES

60. **Aggregate LIP Funding.** At the beginning of each DY, \$1 billion in LIP funds will be available to the State. These amounts will be reduced by any milestone penalties that are assessed by CMS. Two tiers of milestones, as described in paragraph's 61 and 62, must be met for the State and facilities to have access to 100 percent of the annual LIP funds. Funds not distributed in a DY may be rolled over to the next DY.
61. **Tier - One Milestone.** Tier-one milestones are defined as follows:
 - a) Development and implementation of a State initiative that requires Florida to allocate \$50 million in total LIP funding in DY 7 and DY 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim.
 - i. Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;
 - ii. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,
 - iii. Reducing per-capita costs.

Expenditures incurred under this program must be permissible LIP expenditures as defined under Section XIII, Low Income Pool. The State will utilize DY 6 to develop the program. The program must be implemented with LIP funds allocated and expenditures incurred in DYs 7 and 8.

- b) Timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding

Methodology protocol. The State shall submit to CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period. CMS will provide comments to the State on the reconciliation schedules within 30 days. The State will submit the final reconciliation schedule to CMS within 60 days of the original submission date.

- c) Timely submission of all Demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.
- d) Development and submission of an annual “Milestone Statistics and Findings Report” and a “Primary Care and Alternative Delivery Systems Expenditure Report”. Within 60 days following the acceptance of the terms and conditions, the State must submit templates for these reports and anticipated timelines for report submissions.

CMS will assess penalties on an annual basis for the State’s failure to meet tier-one milestones or components of tier-one milestones. Penalties of \$6 million will be assessed annually for each tier-one milestone that is not met. Penalties will be determined by December 31st of each DY and assessed to the State in the following DY. LIP dollars that are lost as a result of tier-one penalties not being met, are surrendered by the State.

62. **Tier-Two Milestones.** Tier-two milestones initiatives must drive from the three overarching goals of the Three-Part Aim as described in paragraph 61(a). The initiatives will focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities must implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served (including low income populations) and meet established hospital specific targets, to receive 100 percent of allocated LIP funding. Tier-two milestones apply to facilities that receive the largest annual allocations of LIP funds and put at risk 3.5 percent of each of these facility’s annual LIP allocation. The milestones apply to the 15 hospitals which are allocated the largest annual amounts in LIP funding. If the total annual LIP funds allocated for the 15 hospitals, do not total at least \$700 million, the population of hospitals must be expanded until \$700 million is reached.

Hospitals will be required to select and participate in 3 initiatives. Depending on the breadth of health care activities undertaken by a facility, CMS may consider exceptions to the requirement that three initiatives must be implemented.

Once a facility is identified as a top 15 hospital, it must continue to achieve milestones to receive future DY LIP funding regardless of whether it drops out of the top 15 category. Exceptions to this requirement may be considered by CMS. Hospitals entering the top 15 category in future DYs will be subject to timelines similar to program planning/success and execution timelines.

A top 15 hospital cannot select quality improvement initiatives under which it is

currently receiving or may be eligible to receive other Federal dollars unless the LIP outcome goals are enhanced over previously established targets.

Within 90 days following the acceptance of the terms and conditions, CMS and the State will, through a collaborative process, finalize the plan and procedures including the specific health care initiatives, investments, and activities, and the applicable standards, measures, and evaluation measures and protocols that will allow for the implementation and monitoring of tier-two milestones and evaluation of the impact of these initiatives. The specific metrics chosen should support the measurements required in paragraph 80 (a)(vii-ix). CMS must approve the final plan and procedures which will require that tier-two facilities receiving funds in SFY 2011-2012 must submit its milestone plan by March 31, 2012, including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone.

Hospital initiatives that can be implemented under tier-two milestones, which are tied to the Three-Part Aim, include the following and are drawn from recent demonstration experiences:

- a) Infrastructure Development – Investments in technology, tools and human resources that will strengthen the organization’s ability to serve its population and continuously improve its services. Examples of such initiatives are:
 - i. Increase in Primary Care capacity including residency programs and externships;
 - ii. Introduction of Telemedicine;
 - iii. Enhanced Interpretation Services and Culturally Competent Care; and,
 - iv. Enhanced Performance Improvement Capacity;
- b) Innovation and Redesign – Investments in new and innovative models of care delivery that have the potential to make significant, demonstrated improvements in patient experience, cost, and disease management. Examples of such initiatives are:
 - i. Expansion of Medical Homes;
 - ii. Primary Care Redesign; and,
 - iii. Redesign for Efficiencies (e.g. Program Integrity).
- c) Population-focused Improvement – Investments in enhancing care delivery for the 5 – 10 highest burden (morbidity, cost, prevalence, etc) conditions/services present for the population in question. Examples of such initiatives are:
 - i. Improved Diabetes Care Management and Outcomes;
 - ii. Improved Chronic Care Management and Outcomes;
 - iii. Reduction of Readmissions;
 - iv. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems);
 - v. Emergency Department Utilization and Diversion;
 - vi. Reductions in Elective Preterm Births; and,
 - vii. PICU and NICU Quality and Safety (e.g. pediatric catheter associated blood stream infection rates).

Between January 1 2012 and March 31, 2012, the tier-two milestone facility’s receiving funds in SFY 2011-2012 must submit a plan/program including baseline data and

outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone. Subsequent year LIP funds allocated to these hospitals will be made available based upon the successful execution of the facilities targeted health care initiatives.

The State must assess a penalty of 3.5 percent of a facility's annual LIP allocation for failing to meet tier-two milestones or components of tier-two milestones. Penalties, if applicable, will be determined by December 31st of each DY (with the exception of DY 6, which will be determined by March 31, 2012) and assessed to the facility in the remaining 6 months of the same DY. LIP dollars that are not paid out as a result of tier-two milestones not being met, are surrendered by the facility and State.

XV. GENERAL FINANCIAL REQUIREMENTS

63. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XVI.
64. **Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit.** All expenditures for health care services for Demonstration participants and categories, as described in section (d), are subject to the budget neutrality agreement. The following describes the reporting of expenditures subject to the budget agreement:
 - a) Tracking Expenditures. In order to track expenditures, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number (11-W-00206/4) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered or for which capitation payments were paid.
 - b) Cost Settlements. For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 and 10C. For any cost settlement not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.
 - c) Pharmacy Rebates. The State may propose a methodology for assigning a portion

of pharmacy rebates to the Demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration and not on any other CMS-64.9 form (to avoid double counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

- d) Use of Waiver Forms. For each DY, a waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter, using the waiver names listed below. The waiver names designate the waiver forms in the MBES/CBES system to report title XIX expenditures associated with the Demonstration.
- i. **Demonstration Population 1 (MEG 1)** – (Aged/Disabled): Aged and disabled Demonstration enrollees.
 - ii. **Demonstration Population 2 (MEG 1)** – (FMR-SSI+DsEldw/oMcare): Aged and disabled individuals without Medicare in non-Reform counties who would be required to enroll in the Demonstration.
 - iii. **Demonstration Population 3 (MEG 2)** – (FMR-TANF): Individuals qualifying under TANF in non-Reform counties who would be required to enroll in the Demonstration.
 - iv. **Demonstration Population 4 (MEG 2)** – (FMR-SOBRA/FC): Individuals qualifying under SOBRA or Foster Care in non-Reform counties who would be required to enroll in the Demonstration.
 - v. **Demonstration Population 5 (MEG 1)** – (FMR->65): Individuals 65 and older in non-Reform counties who would be required to enroll in the Demonstration.
 - vi. **Demonstration Population 6 (MEG 3)** – (Low Income Pool): Demonstration expenditures allowed under the Low Income Pool.
 - vii. **Demonstration Population 7 (MEG 2)** – (TANF & related grp): TANF Demonstration enrollees.

Note: See paragraph 76 for a description of MEGs 1, 2, and 3.

- e) Excluded Services. All expenditures for health care services for Demonstration participants and categories, as described in paragraph 64(d), are subject to the budget neutrality agreement, with the exception of the following excluded services:

- i. AIDS Waiver (Waiver Services);
- ii. DD Waiver (Waiver Services);
- iii. Home Safe Net (Behavioral Services);
- iv. Behavioral Health Overlays Services (Services Only);

- v. ICF/DD Institutional Services;
 - vi. Family & Supported Living Waiver Services;
 - vii. Katie Beckett Model Waiver Services;
 - viii. Brain & Spinal Cord Waiver Services;
 - ix. School Based Admin Claiming; and
 - x. Healthy Start Waiver Services.
- f) Cost-Sharing Adjustments. Applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the Demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by DY on Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to Demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.
- g) Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
- h) Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

65. **Reporting Member Months.** The following describes the reporting of member months for Demonstration Populations.

- a) For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the State must provide to CMS, as part of the Quarterly Report required under paragraph 19, the actual number of eligible member months for the three MEGs described in paragraph 76. The State must provide CMS, upon request, eligible member months by Population as defined in paragraph 64(d). The State must submit a statement accompanying the Quarterly Report which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to

revision.

- b) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.
66. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year (FFY) on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
67. **Extent of FFP.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section XVI:
- a) Administrative costs associated with the administration of the Demonstration;
 - b) Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the Demonstration;
 - c) Net expenditures and prior period adjustments for Medicaid Reform Plan premiums paid to managed care entities and fee for service coverage options;
 - d) Net Expenditures associated with the LIP, as described in Section XIII; and,
 - e) Net Expenditures associated with the EBAP.
68. **Sources of Non-Federal Share.** The State provides assurance that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
- a) CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
 - b) The State shall provide information to CMS regarding all sources of the non-Federal share of funding for any amendments that impact the financial status of the program.

- c) The State assures that all health care related taxes comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

69. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of the Demonstration expenditures are met:

- a) Units of government, including governmentally-operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration;
- b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures;
- c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match;
- d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments; and,
- e) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

70. **MSIS Data Submission.** The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards.

71. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable timeframe.

72. **Program Integrity.** The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration.

XVI. MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the Demonstration. The Demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the Demonstration period. Paragraphs 73 and 74 specify the two independent financial caps on the amount of Federal title XIX funding that the State may receive on expenditures subject to the budget neutrality limit as defined in paragraph 64. Federal financial payments for the Medicaid Reform aspects of the Demonstration are limited by a Per Member Per Month (PMPM) method cap and the payments for the LIP aspects are limited by an aggregate cap.

73. **Budget Neutrality Limit for the LIP.** The LIP amount is capped at \$1 billion total computable for each DY. Funds not distributed in a DY may be rolled over to the next DY. The Federal share of the annual \$1 billion total computable is the maximum amount of FFP that the State may receive during the extension period for the types of Medicaid expenditures for the LIP. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.
74. **Limit on PMPM Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on the Medicaid and Demonstration expenditures identified in paragraph 64 during the approval period of the Demonstration. The limit is determined using a PMPM method. The budget neutrality targets are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire Demonstration. All data supplied by the State to CMS is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS' assessment of the State's compliance with these limits will be done using the CMS-64 Report from the MBES/CBES System.
75. **Risk.** The State shall be at risk for the per capita cost of Demonstration enrollees under this budget neutrality agreement, but not for the number of Demonstration enrollees. By providing FFP for all Demonstration enrollees, the State will not be at risk for changing economic conditions which impact enrollment levels. However, by placing the State at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.
76. **Budget Neutrality Expenditure Limit.** The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration. Demonstration expenditures are defined under the following Medicaid Eligibility Groups (MEGs) as referenced in paragraph 64(d):

- a) MEG 1: SSI
- b) MEG 2: TANF

c) MEG 3 : Low Income Pool

For the purpose of calculating the overall PMPM expenditure limit for the Demonstration, separate budget estimates will be calculated for each year on a Demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire Demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the extension period for the types of Medicaid expenditures for the SSI and TANF MEGs. Budget neutrality calculations for both with and without waiver expenditures are applied on a statewide basis. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year. For the purpose of monitoring budget neutrality, the \$1 billion in annual LIP expenditures is considered as both with and without waiver expenditures.

- a) Projecting Service Expenditures - Each yearly estimate of Medicaid Reform service expenditures will be the cost projections for the SSI and TANF MEGs in sub-paragraph (b) below. The annual budget estimate for each MEG will be the product of the projected PMPM cost for the MEG, times the actual number of eligible member months as reported to CMS by the State under the guidelines set forth in paragraph 65.
- b) Projected PMPM Cost - The PMPM costs for each MEG used to calculate the annual budget neutrality expenditure limit for this Demonstration are specified below.

Demonstration Year	SSI MEG	Trend Rate	TANF MEG	Trend Rate
DY 1 (SFY 2006-2007)	\$ 948.79	8.0%	\$ 199.48	8.0%
DY 2 (SFY 2007-2008)	\$ 1,024.69	8.0%	\$ 215.44	8.0%
DY 3 (SFY 2008-2009)	\$ 1,106.67	8.0%	\$ 232.68	8.0%
DY 4 (SFY 2009-2010)	\$ 1,195.20	8.0%	\$ 251.29	8.0%
DY 5 (SFY 2010-2011)	\$ 1,290.82	8.0%	\$ 271.39	8.0%
DY 6 (SFY 2011-2012)	\$ 1,356.65	5.1%	\$ 285.77	5.3%
DY 7 (SFY 2012-2013)	\$ 1,425.84	5.1%	\$ 300.92	5.3%
DY 8 (SFY 2013-2014)	\$1,498.56	5.1%	\$316.87	5.3%

- 77. **How the Limit will be Applied.** The limits as defined in paragraphs 73 through 76 will apply to the actual expenditures for the Demonstration, as reported by the State under Section XVI. If at the end of the Demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed.
- 78. **Impermissible DSH, Taxes or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations

implemented through State Medicaid Director letters, other memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

79. **PMPM Expenditure Review.** CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, no later than 6 months after the end of each Demonstration year, the State will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in paragraph 19. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide for the PCCM budget limit, if the State exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

<u>Year</u>	<u>Cumulative target definition</u>	<u>Percentage</u>
Year 6	Years 1 through 6 combined budget neutrality cap plus	1 percent
Year 7	Years 1 through 7 combined budget neutrality cap plus	0.5 percent
Year 8	Years 1 through 8 combined budget neutrality cap plus	0 percent

XVII. EVALUATION OF THE DEMONSTRATION

80. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval, within 120 days from the award of the Demonstration, a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on target populations for the Demonstration.
- a) Domains of Focus – The State must propose as least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reducing costs. With respect to domains vii, viii, and ix, the State must propose two research questions under each domain (one each from Tier-One and Tier-Two milestones).
- i. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
 - ii. The effect of customized benefit plans on beneficiaries’ choice of plans, access to care, or quality of care;
 - iii. Participation in the Enhanced Benefits Account Program and its effect on participant behavior or health status;
 - iv. The impact of the Demonstration as a deterrent against Medicaid fraud and abuse;

- v. The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
- vi. The effect of LIP funding on disparities in the provision of healthcare services, both geographically and by population groups;
- vii. The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
- viii. The impact of Tier-One and Tier-Two milestone initiatives on population health; and,
- ix. The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.

b) Evaluation Design – The draft design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

81. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS’ comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the current Demonstration period. The State must submit the final evaluation report within 60 days after receipt of CMS’ comments.

82. **Cooperation with Federal Evaluators.** Should CMS conduct an evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XVIII. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
60 days following the end of the quarter	Quarterly Progress Reports	Section IV, STC 19
120 days following	Annual Report	Section IV, STC 20

the end of the Demonstration year		
30 days following the end of the quarter	Quarterly Expenditure Reports	Section XVI, STC 63
90 days following the award of the Demonstration	Managed Care Policies	Section III, STC 14(a), (b), (d), and (e)
Reporting to begin during DY6	Quarterly Medical Loss Ratio Reporting for Demonstration Counties	Section III, STC 14 (c)
30 days following award of the Demonstration	Premium Assistance Transition Plan	Section IV, STC 21
July 1, 2012	ACA Transition Plan	Section IV, STC 21
60 days following acceptance of the STCs	LIP Reconciliations for DYs 1, 2, and 3	Section XIV, STC 53
30 days following acceptance of the STCs	LIP Reconciliation Schedule for DYs 6, 7, and 8	Section XV, STC 61(b)
60 days following acceptance of the STCs	Templates for Milestone and Expenditure Reports	Section XV, STC 61(d)
120 days following the award of the Demonstration	Draft Evaluation Design	Section XVIII, STC 80
Various	Milestone Deliverables	Section XV, STCs 61 and 62

ATTACHMENT A

Under paragraph 19, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – Florida Medicaid Reform

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 6 (7/1/2011 – 6/30/2012)

Federal Fiscal Quarter: 4/2011 (7/1/2011 – 9/30/2011)

Introduction

Please provide information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”. Enrollment counts should be person counts.

Demonstration Populations (as hard coded in the Form CMS-64)	Total as of end of Current Quarter	Voluntary Disenrolled in Current Quarter	Involuntary Disenrolled in Current Quarter
Population 1 - Aged/Disabled			
Population 2 - FMR-SSI+DsEldw/oMcare			
Population 3 - FMR-TANF			
Population 4 - FMR-SOBRA/FC			
Population 5 - FMR->65			
Population 7 - TANF & related grp			

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Demonstration Approval Period: December 16, 2011 – June 30, 2014

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Consumer Issues

Provide a summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance /Monitoring Activities

Identify any quality assurance/monitoring activity in the current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and Form CMS-64 reporting for the current quarter. Identify the State's actions to address these issues.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS