Florida Managed Medical Assistance Program
1115 Research and Demonstration Waiver
(Project Number 11-W-002064)

Public Notice Document
Waiver Amendment Request
March 27, 2015

Posted on Agency Website
http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth.shtml

Florida Agency for Health Care Administration

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I. Purpose, Goals and Objectives

A. Statement of Purpose

The State is seeking federal authority to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-002064) to assign Medicaid-eligible individuals who are mandated to participate in Florida's MMA program, a component of the Statewide Medicaid Managed Care program, to a managed care plan immediately after eligibility determination. The State is requesting an effective date of September 1, 2015.

The proposed amendment will allow individuals to be enrolled in a managed care plan immediately after eligibility determination. Under the proposed amendment, individuals will receive both their managed care plan assignment and information about the managed care plan choices in their area, to encourage an active selection, immediately after eligibility determination. Appendix D includes a copy of the letter that will be sent to recipients upon Medicaid eligibility determination.

During the initial 30-day period post-enrollment, if a recipient decides to change plans, the change will take effect the first day of the following month. The 30-day change period will be followed by a 90-day disenrollment period. During the 90-day disenrollment period, if a recipient decides to change plans, the change will take effect the first day of the following month.

The State is not requesting any changes to the MMA waiver authorities or expenditure authorities authorized July 31, 2014. The State is requesting to amend Special Term and Conditions (STC) #2, #21, #22, and #40 of this waiver to remove the 30-day delay period between eligibility determination and managed care plan enrollments and to amend the auto-assignment criteria to conform to Section (s.) 409.977(2), Florida Statutes, which states:

> When automatically enrolling recipients in managed care plans, the agency shall automatically enroll based on the following criteria: (a) Whether the plan has sufficient network capacity to meet the needs of the recipients. (b) Whether the recipient has previously received services from one of the plan's primary care providers. (c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans."

The STCs of the MMA waiver can be found at the link provided on page 3 of this document.

Summary Description of the Populations

New enrollees who are mandated to participate in the MMA program include Supplemental Security Income (SSI) individuals, children and families, including pregnant women, and aged, blind, and disabled persons, including those needing institutional care. These mandatory participants are required to enroll in a managed care plan as a condition of receipt of Medicaid benefits. A complete description of mandatory managed care participants can be found on pages 8 and 9 of this document.

The proposed amendment will allow new enrollees who are mandated to participate in the MMA program to immediately take advantage of the robust provider network and access standards required of the plans while allowing these individuals to immediately access the enhanced care coordination and expanded benefits offered by the plans without the 30-day delay period.

B. Goals and Objectives

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

- Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.

- Improving access to coordinated care by enrolling all Medicaid participants in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care).

- Enhancing fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems. Strict financial oversight requirements are established for managed care plans to improve fiscal integrity.

These goals and objectives will empower participants, provide for the accountability of providers, and facilitate program management and fiscal integrity for government. The fundamental elements of the program along with the consumer protections can be found in Section I of the MMA waiver extension. This document can be found on the Agency for Health Care Administrations (Agency's) website at the following link:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/FL_1115_2014-2017_MMA_EXTENSION_REQUEST_SUBMITTED_11-27-2013.pdf.

2. Amendment Summary and Objective:

This amendment is requested to assign Medicaid-eligible individuals who are mandated to participate in the MMA program in a managed care plan immediately after eligibility determination. In addition to the objectives noted earlier for all MMA program enrollees, the objectives of the amendment are to assign new enrollees to immediately take advantage of the following:

- expanded benefits offered by the plans,
- robust provider networks available to plan enrollees,
- higher service level agreements with which plans are required to comply, and
- care coordination resources and services available to plan enrollees.

C. Current Program

1. Managed Care: The State currently operates Florida's Medicaid managed care program under the 1115 MMA Waiver. For a comprehensive description of the MMA program, please see Section III of this document.

1115 MMA Waiver:

On June 14, 2013, the Centers for Medicare and Medicaid Services (Federal CMS) approved an amendment to the demonstration, which retains all of the improvements noted above, but allowed the State to extend an improved model of managed care to all counties in Florida subject to approval of an implementation plan and a determination of readiness based on the elements of the approved plan. The amendment also changed the name of the demonstration to the Florida MMA program.

2. Low Income Pool (LIP): The LIP program provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. It consists of a capped annual allotment of $2.167 billion total computable for 2014-2015. The LIP program is designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Programs include the quality-based LIP programs tracked through metric outcomes to ensure the access to quality care.[1]

D. Federal and State Waiver Authority

The following is a historical description of the federal and state authority granted since authorization of the waiver (Project Number 11-W-00206/4) was obtained in 2005.

1. Initial 5-Year Period (2006-2011): On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" was approved by Federal CMS. The program was implemented in Broward and Duval Counties July 1, 2006 and expanded to Baker, Clay and Nassau Counties July 1, 2007. The program was terminated August 1, 2014 with the implementation of the MMA program. The state authority to operate this program is located in s. 409.91211, F.S., and sunset October 1, 2014.

2. Three-Year Extension Period (2011-2014): On December 15, 2011, the State received Federal CMS approval to extend the waiver to maintain and continue operations of Medicaid Reform for the period July 1, 2011 to June 30, 2014.

3. MMA Waiver Amendment (2014): On June 14, 2013, the State received Federal CMS approval to amend the waiver to terminate the Medicaid Reform program and implement the MMA program as approved by Federal CMS. The name of the waiver was changed to Florida's 1115 Managed Medical Assistance Waiver. The STCs can be viewed on the Agency's website at the following link:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SpecialTermsandConditionsCMSApprovedJuly312014.pdf.

[1] Currently authorized until June 30, 2015.

4. Three-Year Waiver Extension (2014-2017): On November 27, 2013, the Agency submitted an extension request to extend authority for the 1115 MMA Waiver an additional 3 years (July 31, 2014 - June 30, 2017). The Agency received approval of the 3-year extension from Federal CMS on July 31, 2014. The effective dates of the waiver renewal period are July 31, 2014 through June 30, 2017

E. Waiver Amendment Requirements

The State will submit the MMA Waiver amendment to Federal CMS in accordance with STCs #7 and #15 of the MMA waiver and 42 Code of Federal Regulations (CFR) 431.408. The following is a description of the required public notice document.

Public Notice Document: The State is posting this "Public Notice" document to solicit public input 30 days prior to submission of the amendment request to Federal CMS. This public notice document is required to include a comprehensive description of the amendment application that contains sufficient detail to ensure meaningful input from the public, including:

(A) The program description, goals, and objectives of the amendment to be implemented under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration. (See Section I of this document.)

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

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

(D) The hypothesis and evaluation parameters of the demonstration. (See Section VI of this document.)

(E) The specific MMA Waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration. (See Section VII of this document.)

II. Public Process

This section of the document provides a summary of public notice and input process used by the State in compliance with 42 CFR 431.408 and STCs #7 and #15 of the MMA Waiver including: the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to s. 1902(a)(73) of the Social Security Act (SSA) as amended by s. 5006(e) of the American Recovery and Reinvestment Act of 2009.

A. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs[2] located in Florida through written correspondence, to solicit input on the amendment request. Appendix A of this document provides the correspondence sent on March 27, 2015, to the Seminole Tribe and Miccosukee Tribe requesting input on the amendment request.

B. Public Notice Process

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

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

http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-03.shtml

C. Florida Medicaid Advisory Meetings

The Agency is asking for input on this amendment request from the members of the Medicaid Medical Care Advisory Committee (MCAC) and the public at large. The public meeting notices were published in FAR. During the meetings, the Agency will provide a description of the amendment request and will seek to obtain input on the amendment request. The agenda and presentation materials are posted on the Agency's website provided above.

- Public meeting will be held in Tampa on April 7, 2015.
- MCAC meeting will be held in Tallahassee on April 14, 2015.

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

Florida Medicaid's Medical Care Advisory Committee

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

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

D. Public Meetings

The State will publish a public meeting notice in the FAR on March 27, 2015, inviting all interested parties to the two public meetings listed in the table below, which provides the dates, times and locations. Individuals who will be unable to attend the meeting in person can participate via conference call by using the toll-free number provided in the FAR notice. During the meetings, the Agency will provide an overview of the MMA Waiver and description of the amendment request and allow time for public comments. Table 1 provides the schedule of public meetings to be held regarding the proposed amendment.

Table 1
Schedule of Public Meetings

Location	Date	Time
Tampa Agency for Health Care Administration 6800 North Dale Mabry Highway Main Training Room Tampa, FL 33614 Conference Line: 1-877-299-4502 Participant Code: 769 730 07#	April 7, 2015	1:00 p.m. -3:30 p.m.
Tallahassee Agency for Health Care Administration 2727 Mahan Drive Building 3 Conference Room A Tallahassee, FL 32308 Conference Line: 1-877-299-4502 Participant Code: 758 844 10#	April 14, 2015	3:00 p.m. – 5:00 p.m.

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the Agency at least

seven days before the workshop/meeting by contacting Heather Morrison at (850) 412-2034 or by e-mail at Heather.Morrison@ahca.myflorida.com

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

E. Public Notice Document Made Available to the Public

The Agency will post on its website (link provided on page 5) beginning March 27, 2015 through April 26, 2015, this public notice document, the approved MMA Waiver documents (STCs of the waiver and the waiver and expenditure authorities document) and the Florida law (Part IV of Chapter 409, F.S.) that established the MMA program.

F. Submission of Written Comments

The Agency's website provides the public the option of submitting written comments on the amendment request by mail or email (address located below). In addition, the Agency will ask attendees of the public meetings to submit written comments.

Mail comments and suggestions to:

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

The public may also e-mail comments and suggestions to:

FLMedicaidWaivers@ahca.myflorida.com

III. Current Program Overview

The following provides a description of the current MMA program, an integrated health care delivery system, by which eligible recipients will receive their primary and acute medical care services as specified in Florida law and as approved by Federal CMS. The proposed amendment will assign Medicaid-eligible individuals who are mandated to participate in the MMA program to a managed care plan immediately after eligibility determination.

A. Eligibility

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

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

a. Mandatory Managed Care Participants – Individuals who belong to the categories of Medicaid eligibles listed in the following table, and who are not listed as excluded from mandatory participation, are required to be MMA program participants. Table 2 provides a listing of the mandatory managed care participants.

Table 2
Mandatory Managed Care Participants

Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility
Infants under age 1 Population 2	No more than 206% of the Federal Poverty Level (FPL).	Title XIX	TANF & related grp
Children 1-5	No more than 140% of the FPL.	Title XIX	TANF & related grp
Children 6-18 Population 2	No more than 133% of the FPL.	Title XIX	TANF & related grp
Blind/Disabled Children Population 1	Children eligible under SSI, or deemed to be receiving SSI.	Title XIX	Aged/Disabled

Table 2 Mandatory Managed Care Participants			
Mandatory State Plan Eligibility Groups	**Population Description**	**Funding Stream**	**CMS-64 Eligibility**
IV-E Foster Care and Adoption Subsidy Population 2	Children for whom IV-E foster care maintenance payments s or adoption subsidy payments are received – no Medicaid income limit.	Title XIX	TANF & related grp
Pregnant women Population 2	Income not exceeding 191% of FPL.	Title XIX	TANF & related grp
Section 1931 parents or other caretaker relatives Population 2	No more than AFDC Income Level (Families whose income is no more than about 31% of the FPL or $486 per month for a family of 3.)	Title XIX	TANF & related grp
Aged/Disabled Adults Population 1	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by SSA.	Title XIX	Aged/Disabled
Former foster care children up to age 26	Individuals who are under age 26 and who were in foster care and receiving Medicaid when they aged out.	Title XIX	TANF & related grp
Optional State Plan Groups			
State-funded Foster Care or Adoption assistance under age 18	Who receive a state Foster Care or adoption subsidy, not under title IV-E.	Title XIX	TANF & related grp
Individuals eligible under a hospice-related eligibility group	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236 Population 1	This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category in paragraph (c).	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community based waiver group specified at 42 CFR 435.217 Population 1	This group includes institutionalized individuals eligible under this special HCBS waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category in paragraph (c).	Title XIX	Aged/Disabled

b. Medicare-Medicaid Eligible Participants - Individuals fully eligible for both Medicare and Medicaid are required to participate in the MMA program for covered Medicaid services. These individuals continue to have their choice of Medicare providers as this program

does not impact individuals' Medicare benefits. Medicare-Medicaid beneficiaries are afforded the opportunity to choose an MMA plan. However, to facilitate enrollment, if the individual does not elect an MMA plan, then the individual is assigned to an MMA plan by the state using the criteria outlined in STC #22.

c. Voluntary Participants – The following individuals are excluded from mandatory participation under subparagraph (a) but may choose to be voluntary participants in MMA:

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

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

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

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

v. Children receiving services in a prescribed pediatric extended care (PPEC) facility. The has submitted and amendment to CMS to permit this population to voluntarily enroll in the MMA program in accordance with state law that became effective on June 4, 2014. This change will be effective prospectively, following CMS approval of an applicable demonstration amendment; and,

vi. Residents of group home facilities licensed under s. 393.067, F.S., receiving residential services in family living environments including supervision and care necessary to meet their physical, emotional, and social needs.[3]

d. Excluded From MMA Program Participation - The following groups of Medicaid eligibles are excluded from participation in the demonstration.

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

ii. Family planning waiver eligibles; and

iii. Individuals eligible as women with breast or cervical cancer.

e. Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law, are not eligible for Federal Financial Participation.

[3] Pending approval from Federal CMS.

B. Current Enrollment and Disenrollment

The following describes the current enrollment and disenrollment process in accordance with STCs #21 through #25 of the MMA Waiver. The STCs can be found at the link provided on page 3 of this document.

1. New Enrollees: At the time of eligibility determination, individuals who are mandated to participate in the MMA program receive information about plan choices in their region. New enrollees are informed of their options in selecting an authorized plan and are provided the opportunity to talk with a choice counselor to obtain additional information in making a choice. New enrollees are required to select a plan within 30 days of eligibility determination. If the individual does not select a plan within the 30-day period, the Agency assigns the individual into a managed care plan in the MMA program. Once an individual has made their choice, they can contact the Agency or the Agency's designated choice counselor to register their plan selection. Once the plan selection is registered and takes effect, the plan communicates to the enrollee, in accordance with 42 CFR 438.10, the benefits covered under the plan, including dental benefits, and how to access those benefits.

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

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

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

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

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

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

a) To promote alignment between Medicaid and Medicare, each recipient who is enrolled with a Medicare Advantage Organization, is first be assigned to any plan in the recipient's region that is operated by the same parent organization as the recipient's Medicare Advantage Organization. If there is no match of parent organization or appropriate plan within the organization, then the recipient is assigned as in auto-enrollment listed in paragraphs 2(a) -2(d) above.

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

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

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

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

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

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

5. Re-enrollment: In instances of a temporary loss of Medicaid eligibility, which the state is defining as six months or less, the state re-enrolls enrollees in the same managed care plan they were enrolled in prior to the temporary loss of eligibility unless enrollment into the plan has been suspended.

C. Information and Choice

1. Enrollee Choice: The State assures Federal CMS that it complies with section 1932(a)(3) and 42 CFR 438.52, relating to choice since at least two managed care plan options are available in all MMA regions. The State operates the choice counseling program in accordance with STCs #54-58 of the waiver.

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

Through the designated contractor, the Agency 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 are measured consistently for each plan, and the data are made available publicly.

Enrollment materials have been provided in a variety of ways including the internet, print, telephone, and face-to-face. All written materials are written at the fourth-grade reading level and available in a language other than English when five percent of the county speaks a language other than English. The Agency ensures the provision of oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY, as needed without charge to the enrollee. The call center is operational during business days, with extended hours, and is staffed with professionals qualified to address the needs of the enrollees and potential enrollees.

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

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

D. Benefits

1. Customized Benefit Packages: Currently, none of the MMA plans have chosen to offer Customized Benefits Packages and chose to provide all State Plan services as well as Expanded Benefits. Customized benefits are described in STCs #26 -#31 of the waiver. The STCs of the MMA Waiver can be found at the link provided on page 3 of this document.

2. Expanded Benefits under MMA program: Expanded benefits are those services or benefits not otherwise covered in the MMA program's list of required services, or that exceed limits outlined in the Medicaid State Plan and the Florida Medicaid coverage and limitations handbooks and coverage policies and the Florida Medicaid fee schedules. The plans may offer expanded benefits in addition to the required services listed in the MMA Exhibit for MMA plans and Comprehensive LTC plans, and the LTC Exhibit for Comprehensive LTC plans and LTC plans, upon approval by the State. The plans may request changes to expanded benefits on a contract year basis, and any changes must be approved in writing by the State. Table 3 provides a list of the expanded benefits approved by the Agency that are being offered by the MMA standard plans in 2015. Table 4 provides a list of the expanded benefits approved by the Agency that are being offered by the MMA specialty plans in 2015.

Table 3
Expanded Benefits Offered by Standard Plans

List of Expanded Benefits	Amerigroup	Better Health	Coventry	Humana	Integral	Molina	Preferred	Prestige	SFCCN	Simply	Staywell	Sunshine	United
Adult dental services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult hearing services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Adult vision services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Art therapy	Y			Y		Y					Y	Y	
Equine therapy											Y		
Home health care for non-	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y

Table 3 Expanded Benefits Offered by Standard Plans													
List of Expanded Benefits	**Amerigroup**	**Better Health**	**Coventry**	**Humana**	**Integral**	**Molina**	**Preferred**	**Prestige**	**SFCCN**	**Simply**	**Staywell**	**Sunshine**	**United**
pregnant adults (Expanded)													
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Medically related lodging & food		Y		Y	Y	Y		Y		Y	Y	Y	
Newborn circumcisions	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Nutritional counseling	Y	Y	Y	Y	Y		Y	Y		Y	Y	Y	
Outpatient hospital services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Over the counter medication and supplies	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Pet therapy				Y		Y					Y		
Physician home visits	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y
Pneumonia vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Post-discharge meals	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y
Prenatal/Perinatal visits (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Primary care visits for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Shingles vaccine	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Waived co-payments	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Table 4 Expanded Benefits Offered by Specialty Plans						
List of Expanded Benefits	**CMSN Plan**	**Magellan (Serious Mental Illness)**	**Freedom (Chronic/Duals)**	**Sunshine (Child Welfare)**	**Clear Health Alliance (HIV/AIDS)**	**Positive Health (HIV / AIDS)**
Adult dental services (Expanded)		Y		Y	Y	Y
Adult hearing services (Expanded)				Y	Y	Y
Adult vision services (Expanded)		Y		Y	Y	Y
Art therapy				Y		
Equine therapy						Y
Home and Community-Based Services		Y			Y	
Home health care for non-pregnant adults (Expanded)		Y		Y	Y	
Influenza vaccine		Y		Y	Y	Y
Intensive Outpatient Therapy		Y			Y	
Medically related lodging & food		Y		Y	Y	Y
Newborn circumcisions		Y		Y	Y	Y
Nutritional counseling		Y		Y	Y	
Outpatient hospital services (Expanded)		Y		Y	Y	Y
Over the counter medication and		Y		Y	Y	Y

Table 4 Expanded Benefits Offered by Specialty Plans						
List of Expanded Benefits	**CMSN Plan**	**Magellan (Serious Mental Illness)**	**Freedom (Chronic/Duals)**	**Sunshine (Child Welfare)**	**Clear Health Alliance (HIV/AIDS)**	**Positive Health (HIV / AIDS)**
supplies						
Pet therapy						
Physician home visits				Y	Y	
Pneumonia vaccine		Y		Y	Y	Y
Post-discharge meals		Y		Y	Y	
Prenatal/Perinatal visits (Expanded)		Y		Y	Y	Y
Primary care visits for non-pregnant adults (Expanded)		Y		Y	Y	Y
Shingles vaccine		Y		Y	Y	Y
Waived co-payments		Y		Y	Y	Y
NOTE: Details regarding scope of covered benefit may vary by managed care plan.						

3. Benefit Packages: In addition to the expanded benefits available under the MMA program that are listed in Table 3 and Table 4 of this document, the MMA plans provide standard benefits in accordance with the Florida Medicaid State Plan, the Florida Medicaid coverage and limitations handbooks and coverage policies, and the Florida Medicaid fee schedules. Table 5 provides the standard benefits that are provided under the MMA contracts.

Table 5 MMA Plan Services	
(1)	**Advanced Registered Nurse Practitioner**
(2)	**Ambulatory Surgical Center Services**
(3)	**Assistive Care Services**
(4)	**Behavioral Health Services**
(5)	**Birth Center and Licensed Midwife Services**
(6)	**Clinic Services**
(7)	**Chiropractic Services**
(8)	**Dental Services**
(9)	**Child Health Check Up**
(10)	**Immunizations**
(11)	**Emergency Services**
(12)	**Emergency Behavioral Health Services**
(13)	**Family Planning Services and Supplies**
(14)	**Healthy Start Services**
(15)	**Hearing Services**
(16)	**Home Health Services and Nursing Care**
(17)	**Hospice Services**
(18)	**Hospital Services**
(19)	**Laboratory and Imaging Services**
(20)	**Medical Supplies, Equipment, Protheses and Orthoses**
(21)	**Optometric and Vision Services**
(22)	**Physician Assistant Services**

Table 5 MMA Plan Services	
(23)	**Podiatric Services**
(24)	**Practitioner Services**
(25)	**Prescribed Drug Services**
(26)	**Renal Dialysis Services**
(27)	**Therapy Services**
(28)	**Transportation Services**

E. Cost Sharing

Premiums and Co-Payments. The State pre-approves all cost sharing allowed by the plans. Cost-sharing must be consistent with the state plan except that the plans may elect to assess cost sharing that is less than what is allowed under the state plan in accordance with STC #32 of the MMA Waiver. Table 6 provides the current Medicaid State Plan cost sharing limits, including co-payments and co-insurances.

Table 6 Cost Sharing	
Services	**Co-payment / Co-insurance**
Birthing Center	$2 per day per provider
Chiropractic	$1 per day per provider
Community Mental Health	$2 per day per provider
Dental – Adult	5% co-insurance per procedure
Federally Qualified Health Centers	$3 per day per provider
Home Health Agency	$2 per day per provider
Hospital Inpatient	$3 per admission
Hospital Outpatient	$3 per visit
Independent Laboratory	$1 per day per provider
Hospital Emergency Room	5% co-insurance up to the first $300 for each non-emergent visit
Nurse Practitioner	$2 per day per provider
Optometrist	$2 per day per provider
Pharmacy	2.5% co-insurance up to the first $300 for a maximum of $7.50 a month
Physician and Physician Assistant	$2 per day per provider
Podiatrist	$2 per day per provider
Portable X-Ray	$1 per day per provider
Rural Health Clinic	$3 per day per provider
Transportation	$1 per trip

All individuals not exempt by federal regulation are responsible for cost-sharing for services. The Agency reviewed and approved cost-sharing requirements as part of the benefit packages. Consistent with 42 CFR 447.53(b), cost-sharing is not required for children through age 18, pregnant women, institutionalized individuals, emergency service or for family planning services and supplies, unless otherwise authorized by Federal CMS. The Agency encouraged plans during the negotiation process to reduce or waive cost-sharing requirements for preventive

services in order to increase access and decrease dependence on more acute care services. Such services include, but are not limited to, check-ups, vaccinations, pap smears and certain prescribed medication. When a co-payment or co-insurance is required as part of the plan benefit structure, the provider is responsible for collecting payments from individuals.

All MMA plans have waived co-payments as an expanded benefit.

2. Healthy Behaviors: The Agency has required the managed care plans to establish Healthy Behaviors programs to encourage and reward healthy behaviors. For Medicare and Medicaid recipients who are enrolled in both an MMA plan and a Medicare Advantage plan, the MMA plan must coordinate their Healthy Behaviors programs with the Medicare Advantage plan to ensure proper coordination. The Agency monitors to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and an alcohol or substance abuse treatment program that meet all state requirements.

Programs administered by plans comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG). Plans are encouraged to seek an advisory opinion from OIG once the specifics of their Healthy Behaviors programs are determined.

3. Additional Programs: The Healthy Start Program, the Program for All Inclusive Care for Children, and the Comprehensive Hemophilia Program are programs in this demonstration. They were previously authorized under Florida's Section 1915(b) Medicaid Managed Care Waiver.

F. Health Care Delivery System

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

The program ensures individual choice, increased access, improved quality, efficiency and fiscal integrity while stabilizing cost. The program is an integrated model that manages all care. For at least the first year of operation of the MMA program, the plans will be required to use the state's preferred drug list.

2. Regions: Florida law established 11 regions within the State of Florida for the MMA program, and outlines the number of plans authorized to provide services in each region. Table 7 provides a list of the counties by the 11 regions.

Table 7
Regions for the MMA Program

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

Table 7 Regions for the MMA Program	
Region	**Counties**
Region 5:	Pasco and Pinellas
Region 6:	Hardee, Highlands, Hillsborough, Manatee and Polk
Region 7:	Brevard, Orange, Osceola and Seminole
Region 8:	Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota
Region 9:	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
Region 10:	Broward
Region 11:	Miami-Dade and Monroe

3. MMA Plans: Table 8 provides a listing of contracted MMA plans.

Table 8 MMA Plans	
Plan Type	**Plan Name**
Standard Plans	**Better Health** **Integral Quality Care** **Preferred** **Prestige Health Choice** **Simply** **Staywell** **South Florida Community Care Network**
Specialty Plans Plans contracted to provide services to a targeted population	**Clear Health Alliance** **Freedom Health** **Magellan Complete Care** **Positive Health Care** **Children's Medical Services Network**
Comprehensive Plans Plans also contracted to provide LTC services under the 1915(b)(c) Long-term Care Waiver.	**Amerigroup Florida** **Coventry** **Humana Medical Plan** **Molina** **United Healthcare**
Comprehensive & Specialty Plan This MMA plan is also contracted as a specialty plan providing services to a targeted population and LTC services under the 1915(b)(c) Long-term Care Waiver.	**Sunshine Health**

4. Number of Plans per Region: Florida law specified a minimum and maximum number of plans, along with the requirement that, of the total contracts awarded per region, at least one plan shall be a provider service network (PSN) if any PSNs submit a responsive bid. There is a minimum of two plan choices in each of the 11 regions.

Table 9
MMA Plans by Region

	REGION										
MMA Plan Name	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Standard Plans											
Amerigroup Florida, Inc.					X	X	X				X
Better Health, LLC – PSN						X				X	
Coventry Health Care of Florida, Inc.											X
Humana Medical Plan, Inc.	X					X			X	X	X
Integral Health Plan, Inc. d/b/a Integral Quality Care	X					X		X			
Molina Healthcare of Florida				X			X		X		X
Preferred Medical Plan, Inc.											X
Prestige Health Choice		X	X		X	X	X	X	X		X
Simply Healthcare Plans, Inc.											X
South Florida Community Care Network										X	
Sunshine State Health Plan, Inc.			X	X	X	X	X	X	X	X	X
United Healthcare of Florida, Inc.			X	X			X				X
Wellcare of Florida, Inc. d/b/a Staywell Health Plan of Florida		X	X	X	X	X	X	X			X
Specialty Plans											
AHF MCO of Florida, Inc. d/b/a Positive Healthcare Florida HIV/AIDS Specialty Plan										X	X
Florida MHS, Inc. d/b/a Magellan Complete Care Serious Mental Illness Specialty Plan		X		X	X	X	X		X	X	X
Freedom Health, Inc. Chronic Conditions/Duals Specialty Plan			X		X	X	X	X	X	X	X
Simply Healthcare Plans, Inc. d/b/a Clear Health Alliance HIV/AIDS Specialty Plan	X	X	X		X	X	X	X	X	X	X
Sunshine State Health Plan, Inc. Child Welfare Specialty Plan	X	X	X	X	X	X	X	X	X	X	X
Florida Department of Health Children's Medical Services Network Specialty Plan	X	X	X	X	X	X	X	X	X	X	X

5. Specialty plans are designed for a specific population such as, plans that primarily serve children with chronic conditions or recipients who have been diagnosed with the human immunodeficiency virus or acquired immunodeficiency syndrome (HIV/AIDS).

IV. Budget Neutrality

The State is required to provide an estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request. Budget neutrality compliance for the entire waiver is provided in Section V of the waiver extension request. The MMA Waiver extension can be found at the link provided on page 2 of this document.

Budget Neutrality - Amendment

There is no material impact on budget neutrality as a result of enrolling Medicaid-eligible individuals who are mandated to participate in Florida's MMA program in a managed care plan immediately after eligibility determination.

V. Quality Initiatives

A comprehensive description of the State's quality initiatives can be found in Section VI of the waiver extension. The link to the waiver extension is provided on page 2 of this document. The State is measuring plan performance by requiring the MMA plans to collect and report the following performance measures, certified via qualified auditor. Table 10 lists the MMA plan performance measures by measure. Performance measure reporting is based on all enrolled members (or a random sample of them) who meet the eligibility criteria for each performance measure, so if enrollees in the (proposed) newly added populations meet the eligibility criteria for a measure, they will be included in the performance measure calculation.

Table 10 HEDIS Plan Measures	
1	Adolescent Well Care Visits - (AWC)
2	Adults' Access to Preventive/Ambulatory Health Services - (AAP)
3	Annual Dental Visits - (ADV)
4	Antidepressant Medication Management - (AMM)
5	BMI Assessment – (ABA)
6	Breast Cancer Screening – (BCS)
7	Cervical Cancer Screening – (CCS)
8	Childhood Immunization Status – (CIS) – Combo 2 and 3
9	Comprehensive Diabetes Care – (CDC) · Hemoglobin A1c (HbA1c) testing · HbA1c poor control · HbA1c control (<8%) · Eye exam (retinal) performed · LDL-C screening · LDL-C control (<100 mg/dL) · Medical attention for nephropathy
10	Controlling High Blood Pressure – (CBP)
11	Follow-up Care for Children Prescribed ADHD Medication – (ADD)
12	Immunizations for Adolescents – (IMA)
13	Chlamydia Screening for Women – (CHL)
14	Prenatal and Postpartum Care – (PPC)
15	Use of Appropriate Medications for People With Asthma – (ASM)
16	Well-Child Visits in the First 15 Months of Life – (W15)
17	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life(W34)
18	Children and Adolescents' Access to Primary Care - (CAP)
19	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
20	Ambulatory Care - (AMB)
21	Lead Screening in Children – (LSC)
22	Annual Monitoring for Patients on Persistent Medications (MPM)
23	Plan All-Cause Readmissions (PCR)
Agency-Defined	
1	Mental Health Readmission Rate – (RER)
2	Transportation Timeliness (TRT)
3	Transportation Availability (TRA)

Table 10 HEDIS Plan Measures	
HEDIS & Agency-Defined	
1	Follow-Up after Hospitalization for Mental Illness – (FHM)
2	Prenatal Care Frequency (PCF)
Health Resources and Services Administration – HIV/AIDS Bureau	
1	CD4 Cell Count (CD4)
2	Viral Load Monitoring (VLM)
3	Antiretroviral Therapy (ART)
4	Viral Load Suppression (VLS)
CHIPRA Child Core Set/Child Health Check Up Report (CMS-416)	
1	Preventive Dental Services (PDENT)
2	Dental Treatment Services (TDENT)
3	Sealants (SEA)
CMS Adult Medicaid Core Set/Joint Commission	
1	Antenatal Steroids (ANT)
CAHPS Health Plan Survey	
1	Medical Assistance with Smoking and Tobacco Use Cessation

In addition, the MMA plans that serve children only (Child Welfare Specialty Plan and Children's Medical Services Plan) are not be required to report on performance measures specific to adults. These plans are required to report on additional children's measures listed in Table 11.

Table 11 CHIPRA Child Core Set	
1	HPV Vaccine for Female Adolescents – (HPV)
2	Medication Management for People with Asthma – (MMA)
3	Developmental Screening in the First Three Years of Life – (DEVSCR)
AHRQ-CMS CHIPRA National Collaboration for Innovation in Quality Measurement (NCINQ)	
1	Children on Higher than Recommended Doses of Antipsychotics (HRDPSY)
2	Use of Antipsychotics in Very Young Children (PSYVYC)
3	Use of Multiple Concurrent Antipsychotics in Children (CONPSY)

VI. Evaluation Status and Findings

The status and findings of the evaluation for the entire demonstration are provided in Section VII of the waiver extension. The waiver extension can be found at the link provided on page 2 of this document. The Agency is working with Federal CMS to make any needed updates to the evaluation design, comprehensive quality strategy or the oversight, monitoring and measurement of the provisions previously outlined in the MMA Waiver extension document.

Evaluation Design – Amendment

The Agency is working with Federal CMS to complete a final evaluation design of the entire demonstration for the waiver extension period ending June 30, 2017. Upon federal approval and implementation of this amendment, the State will assess the extent to which the new enrollees who are enrolled in an MMA plan immediately after eligibility determination impact the evaluation design, and determine whether and how the evaluation design should be adjusted.

VII. Waiver and Expenditure Authorities

The State is not requesting any changes to the waiver authorities or expenditure authorities authorized July 31, 2014. The State is requesting to amend Special Term and Condition #21, #22, and #40 of the MMA Waiver to remove the 30-day delay period between eligibility determination and managed care plan enrollment for Medicaid-eligible individuals who are mandated to participate in the MMA program. New enrollees will continue to receive 30 days to select a managed care plan after being determined eligible for Medicaid, prior to the 90-day disenrollment period. The STCs of the MMA waiver can be found at the link provided on page 3 of this document.

Appendix B is the Waiver Authorities document and Appendix C is the Expenditure Authorities document of the MMA Waiver as approved by Federal CMS July 31, 2014.

Appendix A
Letters to the Miccosukee Tribe and the Seminole Tribe

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 27, 2015

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

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida that the State of Florida plans to submit an amendment to Florida's 1115 Managed Medical Assistance (MMA) Waiver to the Centers for Medicare and Medicaid Services (CMS). The proposed amendment will allow recipients who are mandatory for enrollment in the MMA program to be enrolled in an MMA managed care plan immediately upon being determined eligible for Medicaid.

The Agency for Health Care Administration (Agency) will conduct a 30-day public notice and comment period prior to the submission of the proposed amendment request to CMS. The 30-day public notice and public comment period will begin March 27, 2015 and end April 26, 2015. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendment from the public.

The first meeting will be held on Tuesday, April 7, 2015, from 1:00 p.m. to 3:30 p.m. at the Agency for Health Care Administration, 6800 North Dale Mabry Highway, Main Training Room, Tampa, FL 33614. The second meeting will be held on Tuesday, April 14, 2014, from 3:00 p.m. to 5:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Dr., Building 3, Conference Room A, Tallahassee, Florida 32308.

If you have any questions about this amendment or would like to hold a call please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/hm

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 27, 2015

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

Dear Ms. Whidden:

This letter is being sent to notify the Seminole Tribe of Florida that the State of Florida plans to submit an amendment to Florida's 1115 Managed Medical Assistance (MMA) Waiver to the Centers for Medicare and Medicaid Services (CMS). The proposed amendment will allow recipients who are mandatory for enrollment in the MMA program to be enrolled in an MMA managed care plan immediately upon being determined eligible for Medicaid.

The Agency for Health Care Administration (Agency) will conduct a 30-day public notice and comment period prior to the submission of the proposed amendment request to CMS. The 30-day public notice and public comment period will begin March 27, 2015 and end April 26, 2015. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendment from the public.

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If you have any questions about this amendment or would like to hold a call please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/hm

Appendix B
Waiver Authorities

WAIVERS FOR FLORIDA'S
MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00206/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

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

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act (Act) and shall enable the state to implement the Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled Medicaid Reform) consistent with the approved Special Terms and Conditions (STCs). These waivers are effective beginning July 31, 2014, through June 30, 2017.

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) and 1902(a)(17)**

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits. (Also this waiver is to permit Florida to offer different benefits to demonstration Population A than to the categorically needy group, through June 30, 2015.)

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. This authority expires on June 30, 2015.

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

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

Appendix C
Expenditure Authorities

EXPENDITURE AUTHORITIES FOR FLORIDA'S
MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00206/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration from July 31, 2014, through June 30, 2017, be regarded as expenditures under the state's Title XIX plan.

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

1. **Demonstration Population A.** Expenditures for health care related costs not to exceed the amount of the individual's enhanced benefit account, for individuals who lose eligibility for Medicaid or demonstration Population A benefits. This expansion population shall be allowed to retain access to the enhanced benefits account for up to 1 year, except in the instance of termination of the demonstration. This authority expires June 30, 2015.

2. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.

3. Expenditures made by Florida for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, and associated projects to support such care, subject to the restrictions placed on the Low Income Pool, as defined in the STCs. This authority expires June 30, 2015.

4. Expenditures for benefits under the enhanced benefits account program. This authority expires June 30, 2015.

5. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program as previously approved under the 1915(b) waiver (control #FL-01) and as described in STCs 64 and 65.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

Through June 30, 2015, 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 (individuals who lose eligibility for Medicaid or demonstration Population A benefits) to health care related costs not to exceed the amount of the individual's enhanced benefit account.

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

To enable Florida to vary the amount, duration, and scope of 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.

Appendix D
Sample Letter

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

<Payee Name>
<Addr-Line1>
<Addr-Line2 >
<City> <State> <Zip Code>

<Letter Date>

0000000123

As Medicaid recipients, each person listed below will receive their health care services through the Managed Medical Assistance (MMA) program, a part of Statewide Medicaid Managed Care. Follow steps 1-3 below to make a choice.

IMPORTANT: Each person listed on this letter is currently enrolled with the plan listed below. The start date for this enrollment is also listed below.

Plan Name: <Managed Medical Assistance Plan> **Plan Start Date:** <effective>

To gain quicker access to your case, please use the following security PIN to enroll: <PIN#>

Step 1: ***Look***

Look at the information in this packet. It includes:

- information on the MMA program
- a list of the plan(s) in your region
- a list of the extra benefits offered by the plan(s)
- the steps you need to take to change your plan
- how to enroll online or by phone
- answers to frequently asked questions

You can also find this same information online at: www.flmedicaidmanagedcare.com

Step 2: ***Choose***

You have rights to change plans. See the back of this letter for Your Rights to Change Plans.

Name	Medicaid #
<Name>	<Medicaid ID>

You may change MMA plans for each person listed in this letter from the plan listed above, if you wish.

For each person, you will need:

- birth date **and**
- either the Medicaid number or Social Security Number.

Step 3: ***Change***

Online **OR** **Call**

www.flmedicaidmanagedcare.com

Please note: If you choose to make changes online you will need to use the Security PIN above. The PIN must be used along with your Medicaid ID or Gold Card number.

Toll-free at 1-877-711-3662 to talk to a choice counselor or request to meet with a choice counselor.

For additional information, please see the brochure in your packet.

See the back for Your Rights to Change Plans.

Appendix D
Sample Letter

YOUR RIGHTS TO CHANGE PLANS

120 Day Change Period

Your enrollment with your plan starts **<Insert dynamic start date>.** You have until **<Insert dynamic 120 day cut-off date>** to change your plan. Any change made will begin the first of the following month.

After this date, if you want to change your plan, you can do so once a year during a special time called Open Enrollment. Before your Open Enrollment period begins, you will receive a reminder letter and information about your plan choices.

If you want to change plans at a time other than during Open Enrollment, you must have a state-approved good cause reason. For more information or to find out if you have a good cause reason, call 1-877-711-3662 or visit www.flmedicaidmanagedcare.com.