Florida
Managed Medical Assistance Program

(Project Number 11-W-00206/4)

3-Year Waiver Extension Request

Submitted on November 27, 2013

1115 Research and Demonstration Waiver
Florida Agency for Health Care Administration

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A. Statement of Purpose

The state is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2014 to June 30, 2017. The waiver is designed to implement a new statewide managed care delivery system that will improve outcomes, improve consumer satisfaction, reduce and control costs and to redesign the Low Income Pool program. The MMA program will build upon the successful elements of the previous demonstration while incorporating stronger protections for consumers as well as higher standards and more significant positive and negative incentives for plans.

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

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

Still in his first term in office, Governor Scott is overseeing successful implementation of the two most significant reforms in the history of Florida's Medicaid program. Both managed care and diagnosis related groups (DRGs) are being adopted with truly statewide reach to such a degree that makes Florida a unique example among states when it comes to improving the quality and cost-effectiveness of health care services under Medicaid. Managed care and DRGs are viewed by many as the two most successful cost control interventions in the history of the U.S. health care system. At the same time, both concepts are decades old.

To continue the effort to shift focus from utilization-based reimbursement to outcome-based reimbursement, the state is requesting to increase funding and reformulate the Low Income Pool program to produce a "System Access and Transformation Incentive Fund". This new LIP-type demonstration project will test new, more modern reform ideas that simultaneously build on the recent managed care and DRG successes and are similarly grand in scale. Refer to Section V.B for details regarding the proposed change.

The state is not seeking any changes the MMA program during the requested waiver extension period. The state requests the current authorities granted by the Centers for Medicare and Medicaid Services (Federal CMS) on June 14, 2013 be continued during the requested waiver extension period.

B. Goals and Objectives

1. Goals and Objectives: The goals of the MMA program are to improve outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The Agency for Health Care Administration (the Agency) envisions a Medicaid program where all recipients will choose their MCO from a list of nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The state's role has changed so that it is largely a purchaser of care,

providing oversight focused on improving access and increasing quality of care. The overall program objectives are:

a. 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.

b. 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).

c. 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 MCOs to improve fiscal integrity.

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

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

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

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

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

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

a. Increasing recipient participation on Florida's Medical Care Advisory Committee and

convening smaller advisory committees to focus on key special needs populations;

b. Ensuring the continuation of services until a primary care or behavioral health provider reviews the enrollee's treatment plan;

c. Ensuring immediate review of recipient complaints, grievances and appeals for resolution as part of the Rapid Cycle Improvement Process;

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

e. Requiring Florida's External Quality Review Organization to validate each plan's encounter data;

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

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

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

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

j. Adding benefits, particularly dental care, disease management and other initiatives that improve health outcomes.

4. Implementation: The implementation plan and schedule were submitted to Federal CMS on October 30, 2013 and has been posted on the Agency 's Statewide Medicaid Managed Care (SMMC) website at the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#MMAA.

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

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

C. Current Program

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

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

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

   The LIP program, a component of the 1115 MMA Waiver, provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. It consists of a capped annual allotment of $1 billion total computable for each year of the waiver. The LIP program is designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Programs include the quality-based LIP programs tracked through metric outcomes to ensure the access to quality care.

   The following three programs that currently operate under the authority of Florida's 1915(b) Medicaid Managed Care Waiver will transition January 1, 2014 under the authority of the 1115 MMA Waiver as specified in Special Term and Condition (STC) #70 and #71 of the waiver. These programs will continue to operate as they do today and will be available in all parts of the state.

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

b. 1915(b) Medicaid Managed Care Waiver: The original 1915(b) Medicaid Managed Care Waiver was approved in January 1990 which allowed for the implementation of the Medicaid Physician Access System (MediPass) that was designed as a managed care alternative for Medicaid recipients. The Medicaid Managed Care Waiver evolved over time into a variety of managed care options including MCOs, Primary Care Case Management Programs (PCCMs), Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). In general, the waiver offers a menu of managed care options from which a recipient may enroll (Health Maintenance Organizations, Frail Elderly program, MediPass

program, Provider Service Networks (PSNs), Prepaid Dental Health Plans, Children's Medical Services (CMS) Network, Healthy Start program and the Hemophilia Management program.) The waiver also established specialized programs for individuals enrolled in MediPass. These programs include the Prepaid Mental Health Plans and the Disease Management program.

D. Federal and State Waiver Authority

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

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

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

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

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

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

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

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

E. Federal Waiver Extension Requirements

The following is an outline of the information that is required to be included in the federal waiver extension requirements.

1. Public Notice Document: In accordance with 42 Code of Federal Regulation (CFR) 431.412 and STC #9 of the waiver, the Agency posted a "Public Notice" document for public review and comment 30 days prior to submission of the final waiver extension request to Federal CMS. The public notice document included a comprehensive description of the waiver extension request that contains sufficient level of detail to ensure meaningful input from the public, including:

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

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

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

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

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

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

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

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

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

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

proposed changes along with the objective of the change and desired outcomes. (Refer to Section I of this document for a narrative summary of the program, program goals and overall objectives, Section IV for specific program objectives and future goals, and Section V.B for proposed changes to funding of the LIP program.)

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

c. Waiver and Expenditure Authorities: Provide a list along with a programmatic description of the waivers and expenditure authorities being requested in the extension. (Refer to Section IX.)

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

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

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

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

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II. Program Overview

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

A. Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   ii. Family planning waiver eligibles;

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

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

B. Enrollment and Disenrollment

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

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

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

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

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

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

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

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

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

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

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

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

d. Newborns of eligible mothers enrolled in a plan at the time of the child's birth will be

automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 90 days after the child's birth.

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

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

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

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

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

a. Coordinating with the contracted plans and the Agency's choice counseling vendor to create a phased transition to ensure that the volume of recipients being transitioned occurs in an organized manner. This will allow recipients to access choice counseling in stages via phone or via internet, and will make it easier for the Agency and its choice counseling vendor to provide excellent customer services during the roll out.

b. Planning, organizing and implementing a thorough desk and on-site review of all plans to ensure processes and systems are in place before recipients are enrolled, including assessing the capacity of the contracted plans' provider networks.

c. Ensuring continuity of care and continued availability of current primary care and behavioral health providers with the new plan by monitoring plan network participation.

d. Ensuring appropriate and timely notice to recipients, including outreach and education to locations and providers frequented by impacted recipients to help recipients understand the changes that are occurring.

e. Engaging key stakeholders and advocacy groups as well as monitoring complaints through the Rapid Cycle Improvement Process.

C. Information and Choice

1. Enrollee Choice

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

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

2. Enrollee Information

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

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

As it does now, the Agency's designated choice counseling vendor will provide information about each plan's coverage in accordance with federal requirements. Additional plan information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, provider network information, prescription drug formulary information and contact information. In addition, the Agency will supplement coverage information by posting performance information on each plan once such data is available. Information provided will include enrollee satisfaction survey results and performance measure data.

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

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

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

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

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

D. Benefits

During the state's negotiation process, the selected MMA plans chose to provide all covered services at the state plan level and decided not to provide customized benefit packages. In addition, the Agency negotiated the following additional benefits with selected plans to improve quality and access to care:

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

The following describes the customized benefit package as approved in the STCs of the waiver. Please note that during the MMA plans' first contract period, they will not offer customized benefit packages.

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

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

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

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

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

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

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

E. Continuity of Care Provisions

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

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

F. Cost Sharing

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

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

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

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

F. Health Care Delivery System

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

The program will maintain individual choice, increase access, improve quality, efficiency and fiscal integrity while stabilizing cost. The program is an integrated model that will manage all care and increase the enrollment of recipients in plans that are capable of managing all of an individual's care. The MMA plans will be required to use the state's preferred drug list during the first year of operation.

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

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Table 1 MMA Program Regions	
Region	**Counties**
Region 1:	Escambia, Okaloosa, Santa Rosa and Walton
Region 2:	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington
Region 3:	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union
Region 4:	Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia
Region 5:	Pasco and Pinellas
Region 6:	Hardee, Highlands, Hillsborough, Manatee and Polk
Region 7:	Brevard, Orange, Osceola and Seminole
Region 8:	Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota
Region 9:	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
Region 10:	Broward
Region 11:	Miami-Dade and Monroe

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

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

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

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

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

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

e. Commitment to quality improvement;

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

g. Documentation of policies for preventing fraud and abuse.

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

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

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

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

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

Please note the state initiated the procurement of the MMA plans on December 28, 2012 and the Notice of Intent of Award was published the Florida Department of Management Services' Vendor Bid System on September 23, 2013. A listing of the plans selected for each region and relevant information about the procurement can be found via the Department of Management Services' Vendor Bid System at: http://www.myflorida.com/apps/vbs/vbs_www.main_menu. Table 3 on page 20 of this document provides a summary of the plans selected in each region.

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

[1] The PSN counts toward the minimum number of plans per region.

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

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

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

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

8. MMA Plans Selected: The Agency initiated the procurement of the plans on December 28, 2012 and Notices of Intent of Award were published on September 23, 2013, October 10, 2013, October 21, 2013, October 24, 2013 and October 31, 2013. The competitive procurement process used to select the MMA plans has been completed in all regions of the state except for Region 11 as of November 27, 2013. Nine of the ten plan contracts have been awarded in Region 11, as the tenth plan contract is under dispute between two plans competing for the contract. A listing of the plans selected for each region and relevant information about the procurement can be found via the Florida Department of Management Services' Vendor Bid System at: http://www.myflorida.com/apps/vbs/vbs_www.main_menu.

As of November 27, 2013, the Agency has selected 14 standard, non-specialty MMA plans through a competitive procurement process. In addition, the Agency selected five companies to provide services to specialty populations, including specialty plans focused on HIV/AIDS, child welfare and foster care, severe and persistent mental illness, and dual eligbiles with chronic conditions. Table 3 on the following page provides a summary of the MMA plans selected in each region. The Agency anticipates executing the plan contracts in January 2014.

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Table 3
MMA Plans Selected by Region
([2]Plans selected as of 9/23/2013, 10/10/2013, 10/21/2013, 10/24/13 and 10/31/2013)

	REGION											
RESPONDENT NAME	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total Number of Awards**
General, Non-specialty Plans												
Amerigroup Florida, Inc.					X	X	X				X*	4
Better Health, LLC - PSN	X					X				X		3
Coventry Health Care of Florida, Inc.											X*	1
First Coast Advantage, LLC - PSN				X								1
Humana Medical Plan, Inc.	X					X			X	X*	X*	5
Integral Health Plan, Inc. d/b/a Integral Quality Care - PSN						X		X				2
Molina Healthcare of Florida							X		X		X	3
Preferred Medical Plan, Inc.											X	1
Prestige Health Choice - PSN		X	X		X	X	X		X		X	7
Simply Healthcare Plans, Inc.											X	1
South Florida Community Care Network										X		1
Sunshine State Health Plan, Inc.			X*	X*	X*	X*	X*	X*	X*	X*	X*	9
UnitedHealthcare of Florida, Inc.			X*	X*			X*				X*	4
Wellcare of Florida, Inc. d/b/a Staywell Health Plan of Florida		X	X		X	X	X	X			X	7
General, Non-specialty Plans Awarded	2	2	4	3	4	7	6	3	4	4	10	46
Specialty Plans												
AHF MCO of Florida, Inc. d/b/a Positive Healthcare Florida HIV/AIDS Specialty Plan										X	X	2
Florida MHS, Inc. d/b/a Magellan Complete Care Serious Mental Illness Specialty Plan		X		X	X	X	X	X	X	X	X	9
Freedom Health, Inc. Chronic Conditions/Duals Specialty Plan			X		X	X	X	X	X	X	X	8
Simply Healthcare Plans, Inc. d/b/a Clear Health Alliance HIV/AIDS Specialty Plan	X	X	X		X	X	X	X	X	X	X	10
Sunshine State Health Plan, Inc. Child Welfare Specialty Plan	X	X	X	X	X	X	X	X	X	X	X	11
Specialty Plans Awarded	2	3	3	2	4	4	4	4	4	5	5	40

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

[2] As of November 27, 2013, the competitive procurement process has been completed in all regions of the state except for Region 11. Nine of the ten possible plan contracts have been awarded in Region 11. The tenth plan contract is under dispute between two plans competing for the contract.

G. Plan Accountability and Monitoring

The Agency is following standard Agency contracting procedures to enter into clear and comprehensive managed care contracts developed in accordance with all state and federal requirements. The overarching goal is to promote the health and well-being of enrollees by assuring enrollee access to services, holding contracted plans accountable for outcomes, promoting quality and cost-effective delivery of services.

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

To ensure access to necessary Medicaid services, the Agency established specific standards for the number, type and regional distribution of providers in plan networks. Specifically, the plans must maintain a panel of preventive and specialty care providers sufficient in number, mix and geographic distribution to meet the needs of the enrolled population. The plans are also required to maintain a provider network sufficient to serve a percentage of recipients in the region, as established by the Agency, such that, if any one plan leaves a region, the remaining plans have immediate capacity in their provider network (primary care and specialist) to serve all recipients in that region. The plans are required to have providers available within travel and distance standards established by the Agency. The plans may limit the providers in their networks, if network adequacy standards are met, but must also include providers classified in Florida law as “statewide essential provider”. The plans will be required to negotiate in good faith with statewide essential providers for one year. The plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith.

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

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

2. Plan Accountability and Performance Standards: The Agency has enhanced the monitoring activities from the current Medicaid managed care program to provide enhanced plan accountability and clear performance standards. These enhanced requirements include, but are not limited to: posting of formulary or preferred drug list on the plan’s Website and to ensure the list is updated within 24 hours of any change; acceptance of electronic prior authorization requests; establishment of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives and disincentives for network providers; collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS) measures with results published on each plan Website; accreditation within one year of contract execution; establishment of programs and procedures to improve pregnancy

outcomes and infant health; and notification of the Agency of the impending birth of a child to an enrollee.

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

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

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

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

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

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

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

4. Program Integrity: The state assures that the Medicaid program integrity system will require each Medicaid MCO to comply with Section 1932(d)(1) of the SSA and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The state will prohibit any of the Medicaid MCOs from knowingly having a relationship with:

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

The prohibited relationships are:

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

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

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

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

H. Penalties and Sanctions

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

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

required to reimburse the Agency for the cost of enrollment changes and other transition activities.

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

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

I. Quality Initiatives

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

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

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

- Coverage and authorization of services
- Systems performance

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

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

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

The Agency assures Federal CMS that it complies with section 1932(c) of the SSA and 42 CFR 438.200, Quality Assessment and Performance Improvement. All plans will be required to comply with applicable provisions. In accordance with STC #118d, the Agency submitted the required draft Comprehensive Quality Strategy by October 10, 2013.

J. Rapid Cycle Improvement Process

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

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

K. Comprehensive Outreach and Education Strategy

Overall Outreach and Communication Strategy

The Agency has developed a multi-pronged outreach and communication strategy for sharing information about the MMA program. The Agency has separate strategies for outreach to recipients, providers and other stakeholder groups, yet there are some common resources available to all audiences. For example, the Agency has created a dedicated Website, www.myflorida.com/SMMC, specifically for the SMMC program. The Website has dedicated sections for both the Long-term Care (LTC) program and the MMA program. The Website includes a calendar of events, which will be populated with the dates of mailings, webinars and public meetings. It also displays the email address dedicated to the SMMC program (FLMedicaidManagedCare@ahca.myflorida.com) where questions, comments or concerns can be submitted. All questions are responded to and included in the posted Frequently Asked Questions document. The posted Frequently Asked Questions document is in a searchable PDF format with a table of contents and includes sections for LTC and MMA. The posted Frequently Asked Questions document is updated regularly with new questions and includes the date for which the most recent update was made.

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

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

With the MMA program being the second phase of SMMC to be implemented, the Agency has been broadly communicating about it for more than two years since the legislation that created the program became law. Since that time, the Agency has shared information about both LTC and MMA to stakeholder groups. The communication and outreach strategy delineated in the MMA Implementation Plan is a prospective plan for MMA-specific communication activities, which are anticipated to begin in December 2013. A detailed description of the Agency's Comprehensive Outreach and Education Strategy is provided in the MMA Implementation Plan (pages 7-10) which can be viewed at the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_1115_MMA_IP_10-30-2013_Final.pdf.

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III. Public Process

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

A. Public Process Strategy

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

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

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

A summary description of the public notice process and the public meetings are provided on in Section III.C-H of this document.

B. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs[3] located in Florida through written correspondence and conference calls, to solicit input on the waiver extension request and post award forum. Appendix A.3 of this document provides the correspondence sent on September 19, 2013, to the Seminole Tribe and Miccosukee Tribe requesting input on the waiver extension request. The Agency held conference calls[4] with representatives from the Seminole Tribe and Miccosukee Tribe to solicit input on the waiver extension request and post award forum. The Seminole Tribe representative and the Miccosukee representative, each stated during the conference calls that enrolled members of their tribes are not eligible for Medicaid due to income limits and thanked us for explaining the changes to the Medicaid program being implemented through the waiver.

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

C. Public Notice Process

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

- Published public notices for the three public meetings and two advisory meetings in the Florida Administrative Register (FAR) in compliance with Chapter 120, F.S. (Refer to Appendix A.4)
- Emailed 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. (Refer to Appendix A.5)
- Mailed letters to members of the Florida Legislature announcing the meetings. (Refer to Appendix A.6)
- Released Agency Media Alerts announcing the meetings. (Refer to Appendix A.7)
- Posted 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 the waiver extension public notice document. The meeting materials and the waiver extension public notice document is available at the following link:

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

D. Florida Medicaid Advisory Meetings

The Agency requested input on the extension request from members of the two key Medicaid advisory groups listed below. The public meeting notices for the advisory groups were published in FAR. During the meetings, the Agency provided an overview of the MMA program amendment approved June 14, 2013, a description of the extension request and solicited input on the waiver extension request. The agenda and presentation materials are posted on the Agency's website at the links provided below:

- LIP Council meeting held August 8, 2013; http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/Archive/2013.shtml .
- Medicaid Medical Care Advisory Committee meeting held October 15, 2013; http://www.fdhc.state.fl.us/medicaid/mcac/Archive/2013.shtml.

The following is a brief summary of the advisory committee meetings held on the waiver extension request. (Refer to Section III.H for a summary of all public comments received on the waiver extension request.)

- The Agency held a public meeting on the waiver extension request with the LIP Council on August 8, 2013. During the meeting, the Agency provided an overview of the three-year waiver extension and solicited input on the future of the LIP program. The Agency also provided an overview of other states quality incentive programs and solicited input on the approaches available under the waiver extension period. The LIP Council recommended the Agency pursue additional funding to implement quality incentive programs.

- The Agency held a public meeting with the Medical Care Advisory Committee on October 15, 2013. During the meeting, the Agency provided a detailed overview of the waiver

extension request, the implementation of certain provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 related to Title XXI Children's Health Insurance Program in 2014 and the intent to seek additional funding for the Low Income Pool program to establish quality incentive programs. Comments and recommendations from the committee are incorporated in the summary of public comments provided in Section III.H.

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

1. Florida Medicaid's Medical Care Advisory Committee

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

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

2. Low Income Pool Council

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

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

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

- Make recommendations on the financing of the LIP and the disproportionate share hospital program and the distribution of their funds.
- Advise the Agency on the development of the low-income pool plan required by the Federal CMS pursuant to the waiver.

- Advise the Agency on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.
- Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year.

The LIP Council will sunset on October 1, 2014.

E. Public Meetings

The Agency published a public meeting notice in the FAR on October 2, 2013, inviting all interested parties to the three public meetings listed in the table located on the following page, which provides the dates, times and locations. Individuals who were unable to attend the meeting in person could participate via conference call by using the toll free number provided in the FAR notice. Refer to Appendix A.4 for the FAR notice. During the meetings, the Agency provided an overview of the provisions in Part IV of Chapter 409, F.S., related to the MMA program, an overview of the existing waiver including the June 14, 2013 federally approved waiver amendment, a description of the extension request and time for public comments. A link to the video recording of the public meeting held in Tallahassee on October 11, 2013, was posted on the Agency's website following the meeting. The following is the link to the video: http://thefloridachannel.org/video/101113-agency-for-health-care-administration-meeting-on-managed-medical-assistance-waiver.

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

F. Public Notice Document Made Available to the Public

The Agency posted on its website (link provided on page 28) from October 1, 2013 through October 30, 2013, the public notice document, the approved waiver documents (STCs of the waiver as well as the waiver and expenditure authorities document) and the Florida law (Part IV of Chapter 409, F.S.) that established the MMA program.

G. Submission of Written Comments

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

Mail comments and suggestions to:

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

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

FLMedicaidWaivers@ahca.myflorida.com

H. Summary of Public Comments

The following summarizes the public comments received during the 30-day comment period for the waiver extension request that began October 1, 2013 and ended October 30, 2013. A total of 219 individuals attended the public meetings and 78 comments or questions were received during the public comment period. Table 4 provides the total number of participants for each of the public meetings.

Table 4
Total Number of Participants by Public Meeting

Date	Type of Meeting	Location	Number of Participants
August 8, 2013	LIP Council	Tallahassee	13
October 8, 2013	Public Meeting	Tampa	56
October 9, 2013	Public Meeting	Miami	65
October 11, 2013	Public Meeting	Tallahassee	63
October 15, 2013	Medical Care Advisory Committee[5]	Tallahassee	22
Total			**219**

Summary of Comments

The comments received are grouped by topic with an explanation ***(bolded and italicized)*** describing how issues raised are addressed in the plan contract, competitive procurement process, state law or rule.

[5] Due to technical difficulties with the conference call, the two council members who attended by conference call were unable to participate during the first part of the meeting held on October 15, 2013 from 1pm to 4pm.

Pharmacy Services

- Concerns were expressed about a potential shift in utilization to mail order or out of state pharmacies under the expansion of managed care. A related general concern was expressed related to the Florida Medicaid program implementing statutory provisions which allow expanded mail order of pharmacy products.

  Specific requirements in the MMA program were established to ensure recipients receive medically necessary pharmacy services in a timely manner. Managed Care Plans must ensure that regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties are met and maintained throughout the life of the contract. Some of the contract requirements, specific to pharmacy services are outlined below:

  - ***There must be at least one pharmacy for every 2,500 enrollees in a region.***
  - ***In urban areas, a pharmacy must be available to an enrollee within a 30 minute drive or 20 mile distance.***
  - ***In rural areas, a pharmacy must be available within a 60 minute drive or 45 mile distance.***

  MMA plans may choose to utilize mail order pharmacies to provide various services, including expanded benefits, but may not require enrolled recipients to utilize mail order pharmacies exclusively as a pharmacy services provider. In addition, mail order pharmacies cannot be used to meet the network adequacy requirements that are established in the contract.

- Concerns were expressed related to manufacturer rebates.

  In 2010, the federal law changed to require states to collect manufacturer rebates for claims reimbursed by Medicaid managed care plans. Currently, managed care plans (or their pharmacy benefit managers) may negotiate with manufacturers for supplemental rebates. The new MMA contracts will prohibit plans from negotiating rebates directly with manufacturers, and all federal and supplemental rebates paid for claims reimbursed by Medicaid plans will be paid directly to the state.

ARNP Participation

- Concerns were expressed that Advanced Registered Nurse Practitioners will not be included as eligible primary care providers under the MMA program.

  The current managed care contract and the MMA contract provide a definition of primary care provider to include Advanced Registered Nurse Practitioners (ARNP). Neither the statutory nor the plan contract language for the MMA program preclude the use of ARNPs as primary care providers.

Subcontractor Concerns

- Questions were received from durable medical equipment providers regarding the subcontracting process and how it will work under Managed Medical Assistance program. For example, will the MMA plans be allowed to contract with network managers who contracts with durable medical equipment providers?

Managed care plans may delegate some of their functions or responsibilities for providing services (e.g., credentialing) under the MMA program. However, if a managed care plan chooses to delegate some of its functions related to network management, the plan must still comply with network adequacy standards outlined in the contract. This includes regional provider ratios and provider-specific geographic access standards for recipients in urban or rural counties.

Provider Grievance Process

- Concerns were expressed by providers that a strong provider grievance process will need to be established for the MMA program. Providers stated concerns about being locked into a contract with a poor performing MMA plan.

  Providers may appeal claim disputes through the plan or through the state's independent dispute resolution organization. A description of the independent dispute resolution process is provided at the following link: *http://ahca.myflorida.com/MCHQ/Managed_Health_Care/SPHPClaimDRP/claimsdisputeprogramsummary.pdf.* ***No provider is required to contract with any managed care plan, and there is no state requirement that locks providers into contracts with managed care plans, and contracts without a cancellation clause are rare. Providers that are concerned about being locked in, however, should ensure that they only sign contracts that have a termination clause.***

Provider Access to Risk Adjustment Data

- Requests received to access to data the Agency used to establish risk adjusted rates.

  The Agency will respond to public requests for data within constraints related to protecting personal health information as required by both the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and by 42 CFR 431.300-306.

Access to Certain Services

- Concerns were expressed regarding the provision of inpatient psychiatric services to children through the MMA program.

  The state's current Section 1915(b) Statewide Inpatient Psychiatric Program waiver will continue to operate until that federal authority expires on 12/31/2013. After that time and until the MMA program is implemented, inpatient psychiatric services for children will continue to be offered under the authority of Florida's Medicaid State Plan. During this period, inpatient psychiatric services for children will continue to be reimbursed on a fee-for-service arrangement. Upon implementation of the MMA program, inpatient psychiatric services for children will be provided by the MMA plans in accordance with the plan contract. The MMA plans and service providers will be required to comply with the state's rules and coverage and limitations policies.

- Concerns were raised regarding the State's implementation of recent statutory changes that allow foster care children to continue to receive services up to age 21.

  The Agency is in the process of updating its coverage and limitations handbooks to reflect this statutory change and has also submitted a state plan amendment to modify Medicaid eligibility requirements. Managed Medical Assistance plans will be required to continue to provide services to this population up to the age of 21.

- A recommendation was received that smoking cessation medications be included as a covered service and alcohol and drug screenings become more thorough for Medicaid recipients.

  Smoking cessation prescription products are already covered services under the Florida Medicaid program. Approved drug categories related to smoking cessation are listed on the Medicaid preferred drug list (PDL). In order to promote an effective transition of recipients during implementation of the MMA program, the Agency will require that plans use the Medicaid PDL during the first year of operation. Therefore, MMA plans must provide smoking cessation medications consistent with the Agency PDL to enrollees who want to quit smoking. After the first year of operation MMA plans may develop a plan-specific PDL for the Agency's consideration, if requested by the Agency at that time.

  In addition, the MMA plans are required to offer healthy behavior programs that encourage and reward behaviors designed to improve the enrollee's overall health. More specifically, the plans are required to implement a medically approved smoking cessation program. Plans may choose to utilize different therapeutic approaches to aid an enrollee who wishes to quit smoking, which may include the use of prescription medications.

  The MMA plans are also required to implement a medically approved alcohol or substance abuse recovery healthy behavior program. Under this program, MMA plans must offer annual alcohol or substance abuse screening training to their providers. In addition, primary care providers must screen managed care enrollees for signs of alcohol or substance abuse as part of the evaluation at the following times:

  - ***Initial contact with a new enrollee***
  - ***Routine physical examinations***
  - ***Initial prenatal contact***
  - ***When the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services***
  - ***When documentation of emergency room visits suggests the need.***

- Concerns were expressed about potential delays with obtaining prior authorization for hospice services since recipients often cannot wait 24 to 48 hours for approval.

  Managed Medical Assistance plans are not required to prior authorize every covered service. Therefore, some managed care plans may choose to not prior authorize hospice service. However, if authorization is required, MMA plans must process the request and make a decision as expeditiously as the enrollee's health condition requires.

- Concerns were expressed about the participation of limited mental health assisted living facilities in the MMA program.

  The Agency is involved in discussions with owners/operators of assisted living facilities with limited mental health licenses and managed care plans to address the special needs of these recipients as we expand managed care across the state. One of the goals of these discussions is to build bridges between the assisted living facilities, managed care plans, and providers of behavioral health care treatment to ensure that recipients have a stable living environment and access to the care they need to maintain residency in a community setting of their choice.

Plan Accountability and Monitoring

- Recommendation was received that the Agency monitor the plan's financial data reported closely to ensure the accuracy of the plan's medical loss ratio reports and prevent fraud.

  The Agency is establishing new financial reporting requirements that will support additional plan financial monitoring, medical loss ratio justification, and calculation of the achieved savings rebate outlined in s. 409.967(3), F.S.

- Recommendation was received to use "secret shoppers" and other methods to ensure provider availability.

  The Agency will utilize multiple monitoring and evaluation tools to ensure managed care plans are compliant with network adequacy standards.

Program Participation

- Comments received indicated that some individuals were unclear about whether or not certain groups (family members, dually eligible recipients, and individuals with developmental disabilities) will be required to participate in the program.

  In general, all individuals eligible for Medicaid will receive coverage through an MMA plan upon full implementation except for groups specified in state law and the terms and conditions of the waiver. Prior to implementation of the program in a region, information regarding enrollment in the program will be made available to impacted recipients through the Agency's website and other publications. In addition, the Agency has developed a comprehensive education and outreach program that is outlined in the MMA Implementation Plan posted on the Agency's website at the following link:
  http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_1115_MMA_IP_10-30-2013_Final.pdf

  Individuals eligible for Medicare and Medicaid services are required to enroll in a MMA plan in accordance with state law and the terms and conditions of the waiver.

  Individuals enrolled in the developmental disabilities (iBudget) waiver may voluntarily choose to enroll in an MMA plan in accordance with state law and the special terms and conditions of the waiver.

Provider Network Adequacy

- Concerns were expressed regarding the MMA plans provider network standards.

  In order to ensure access to necessary Medicaid services, the Agency established specific standards for the number, type, and regional distribution of providers in plan networks.

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

Plans may limit the providers in their networks but must include certain provider types and also certain providers that are specified in Part IV of Chapter 409, F.S., as "statewide essential."

- Concerns were expressed regarding network adequacy that out-patient dialysis facilities also be listed on the Provider Network Standards list.

  Managed Medical Assistance plans must develop and maintain a provider network that meets the needs of enrollees, including contracting with a sufficient number of credentialed providers to furnish all covered services. MMA plans must ensure that each covered service is provided promptly and is reasonably accessible. Recipients will be able to select an MMA plan in their region that has the service providers that are important to them. To assist in their decision making, enrollees with have access to a list of available dialysis centers in each plan's network. Recipients can select the plan whose network includes the dialysis center best meeting their needs in terms of convenience of location and enrollee experience or preference.

Cost Sharing Requirements

- Concerns were expressed related to the recipient cost sharing requirements not complying with federal regulations and creating a barrier for recipients seeking needed medical care.

  Cost-sharing must be consistent with the Medicaid State Plan except that the plans may elect to assess cost sharing that is less than what is allowed under the state plan and federal regulations. MMA plans are allowed to assess nominal cost sharing in accordance with federal regulations. A description of the nominal cost-sharing, including co-payments and co-insurances, for the MMA plans in accordance with federal regulations is provided in Section II.F of this document. The Agency will pre-approve all cost sharing arrangements proposed by the MMA plans.

Timeline for Implementation

- Comments were received asking for the timeline for implementing the program.

  The Agency submitted the required implementation plan to Federal CMS for approval on October 30, 2013. The implementation plan includes the proposed implementation schedule of the program, which is subject to approval by Federal CMS. The document is posted on the Agency's website at the following link: *http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/FL_1115_MMA_IP_10-30-2013_Final.pdf .*

Plan Assignment Process

- Questions were received asking how the enrollment and plan assignment process will work under the MMA program.

  The Agency will follow the enrollment and disenrollment process outlined in this document in Section II.C, and as provided in the special terms and conditions of the waiver as approved on June 14, 2013.

Low Income Pool Program

- A recommendation was received urging the state to seek increased funding for the Low Income Pool program.

As part of the waiver extension request, the Agency is seeking an increase in funding for the Low Income Pool program (Refer to Section V.B of this document for a description of this request).

- A recommendation was received urging the state to develop protocols for LIP providers to coordinate with enrollment activities under the Affordable Care Act.

  The Agency will work with CMS and LIP providers to establish activities and programs to be funded through the LIP.

<u>Other issues included in written comments received through the mail or email included:</u>

- Comments were received in support of the state's goals to decrease the administrative burden related to prior authorizations and the ability for providers to process prior authorizations electronically under the MMA program.

  The Agency appreciates the feedback that it has received from the public on the enhanced standards that will be included in the MMA program.

- Concerns were expressed regarding the reimbursement rate for dental care services for vulnerable populations receiving life maintenance procedures.

  Managed Medical Assistance plans will have greater flexibility in reimbursing providers at a rate higher than what is published on the Medicaid fee schedules, if that is needed to assist an enrollee in accessing services.

- Concerns were expressed regarding limited access to the Mom Care program of prenatal care for all women presumptively eligible for Medicaid under SOBRA.

  Under the MMA program, women who are eligible for Medicaid under SOBRA will be enrolled in an MMA plan and have their prenatal care coordinated through the managed care plan. The MMA plans will be responsible for ensuring these women have access to the full array of prenatal care necessary to promote a healthy birth – comparable to what they received through the MomCare program.

- Comments and suggestions were received regarding continuity of quality care for persons with disabilities, which included:

  - Increasing consumer protections that require plans to separately measure referrals to specialists,
  - Participation in disability awareness training by managed care providers, and
  - Increasing access to specialty care.

  The provider network standards developed for the MMA program are more comprehensive than any prior network standards established by the Agency. The MMA plans must enter into provider contracts with a sufficient number of specialists to ensure enrollees of all ages have access to the services needed. The MMA plans must maintain written care coordination/case management and continuity of care protocols that include a mechanism for direct access to specialists for enrollees identified as having special health care needs, as appropriate for their conditions and identified needs. Further, the MMA plans are required to submit a provider network file of all participating providers on a weekly basis. This report can be used to

monitor the plan's compliance with network adequacy requirements and access to care standards.

The MMA plans are also required to offer training to all providers and their staff regarding the special needs of enrollees.

The Agency has also adopted specific quality performance measures under the MMA program that focus on improving the health outcomes for individuals with special health care needs.

- Comments were received on the state's Comprehensive Quality Strategy regarding quality initiatives, Medicaid Fair Hearing reporting, and the grievance and appeal process for beneficiaries.

  The Agency considered all comments received in the development of the draft Comprehensive Quality Strategy submitted to Federal CMS on October 10, 2013. The Agency will work with Federal CMS to finalize the strategy in accordance with the terms and conditions of the waiver.

- Concerns were expressed with the existing Medicaid Reform program prior to implementation of the MMA program to include:

  - Urging Federal CMS to not grant additional waiver authority until roll out of the MMA program has completed and is thoroughly evaluated.
  - Concerns with utilization rates being used as a basis for reporting care received.
  - Urging the Agency take additional measures to ensure the expansion of Medicaid.
  - Building in additional opportunities to receive and meaningfully use public input from all stakeholders.

  Section III of the document describes the public input process the state utilized to solicit feedback on the three-year extension request for the 1115 MMA waiver. All comments received were considered in the development of this waiver extension request. Section VI of this document provides the quality initiatives, including plan performance that occurred during the current waiver period and outlines the quality initiatives that will be undertaken during the proposed extension period.

  The Agency will continue to solicit feedback from the public (public meetings, web based training sessions, etc.) as we implement the new program.

Please note that comments received as of November 21, 2013 after the end of the 30-day public comment period, fall into the groupings discussed above. The Agency took all comments received under consideration in the development of this waiver extension request.

The Agency established a dedicated email box (FLMedicaidWaivers@ahca.myflorida.com) to receive comments on an ongoing basis regarding the MMA program.

IV. Program Objectives of the Waiver

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

A. Program Objectives

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

Objective 1: To ensure there is an increase in the number of plans from which an individual may choose; an increase in the different type of plans[6]; increased patient satisfaction.

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

As illustrated by the Tables 5 through 7 located on page 39 of this document, the number and types of Reform health plans have increased in each geographical pilot area since the implementation of the waiver. Since the Reform health plans have the ability to create customized benefit packages to meet the needs of specific populations, Florida Medicaid recipients have a greater number of health plans from which to choose along with a greater variety of benefits. This flexibility empowers the recipients to choose the plan that best meets their needs. An exciting aspect of the waiver is the development of specialty plans. Florida Medicaid now has, as a result of the waiver, a health plan that specializes in serving children with chronic conditions and a health plan that specializes in serving individuals living with HIV or AIDS. As each specialty plan was developed, the Agency worked closely with medical professionals and national experts to ensure the model contracts encompass the unique needs of each population.

Tables 5 through 7 show the number of Reform health plans by plan type before implementation of the waiver on July 1, 2006 and the number of health plans as of August 1, 2013. Prior to the waiver, there were no specialty plans. Now there are three specialty plans in Broward County and one in Duval County. Similarly, there was one PSN in Broward County and none in Duval County prior to the waiver. Now there are two PSNs in Broward and one in Duval. The waiver has brought managed care to Baker, Clay and Nassau Counties. There are now three HMOs and one PSN serving these counties.

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

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

Table 5 Comparison of Number and Type of Health Plans in Broward County (As of August 1, 2013)		
Type of Health Plan	**# Pre-Reform**	**# in Reform**
HMO	8	9
PSN	1	2
Specialty Plan	0	3
Total	**9**	**14**

Table 6 Comparison of Number and Type of Health Plans in Duval County (As of August 1, 2013)		
Type of Health Plan	**# Pre-Reform**	**# in Reform**
HMO	2	3
PSN	0	1
Specialty Plan	0	1
Total	**2**	**5**

Table 7 Comparison of Number and Type of Plans in Baker, Clay and Nassau Counties (As of August 1, 2013)		
Type of Health Plan	**# Pre-Reform**	**# in Reform**
HMO	0	3
PSN	0	1
Specialty Plan	0	0
Total	**0**	**4**

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

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

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

a. Access to Services Not Previously Covered

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

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

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

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

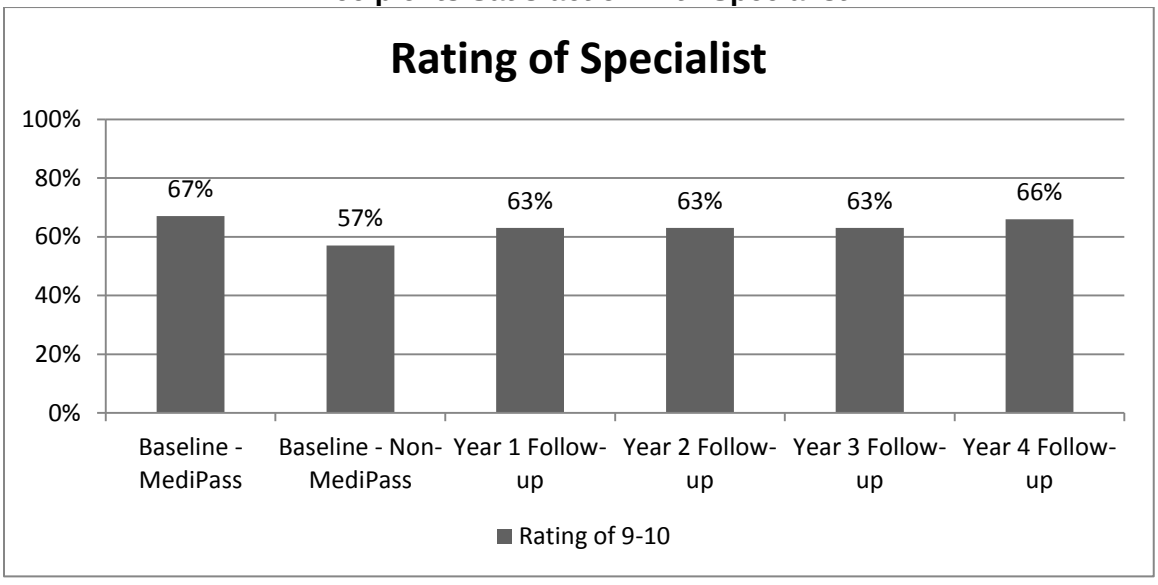
2. Improved Access to Specialists

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

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

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

Chart A
Recipients Satisfaction with Specialist



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

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

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

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

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

  The Agency continues to monitor the Fair Hearings on a quarterly basis to identify issues or trends of concern. Table 8 located on the following page identifies the number of Medicaid Fair Hearing Requests and the number of Fair Hearings held.

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

- From March 2008 through March 2009, the Agency headquarters staff and field office staff conducted 11 monthly plan Provider Network Validation surveys. These surveys assessed the percentage of health plan providers in the network files that are in fact contracted with the health plans. In the last six monthly surveys (September 2008 thru March 2009), the accuracy rates were consistently 99% or 100%, so the survey process was moved to a quarterly basis beginning in July 2009. Table 9 located on the following page provides the survey results for the period March 2008 through March 2009.

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

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

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

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

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

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

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

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

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

Chart B
Specialty Care – Reform Counties SFY 2009-10

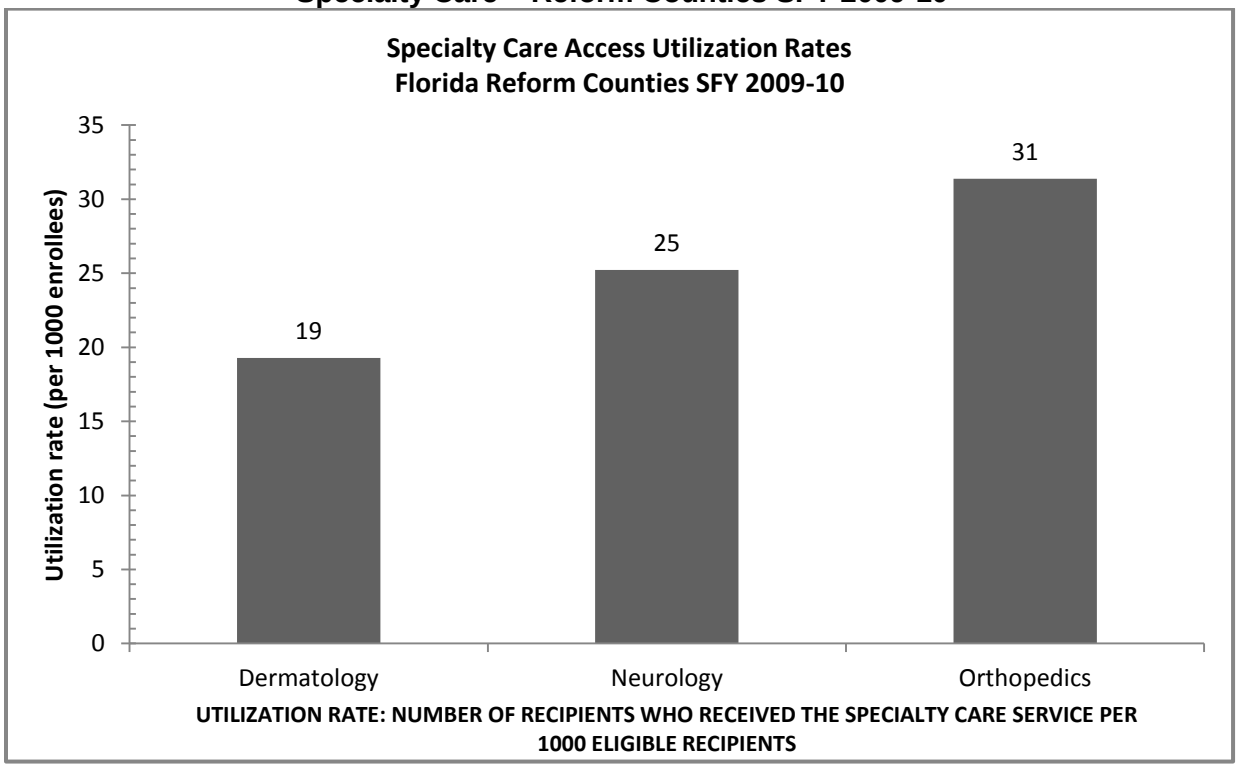

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Chart C
Specialty Care – Reform Counties SFY 2009-10

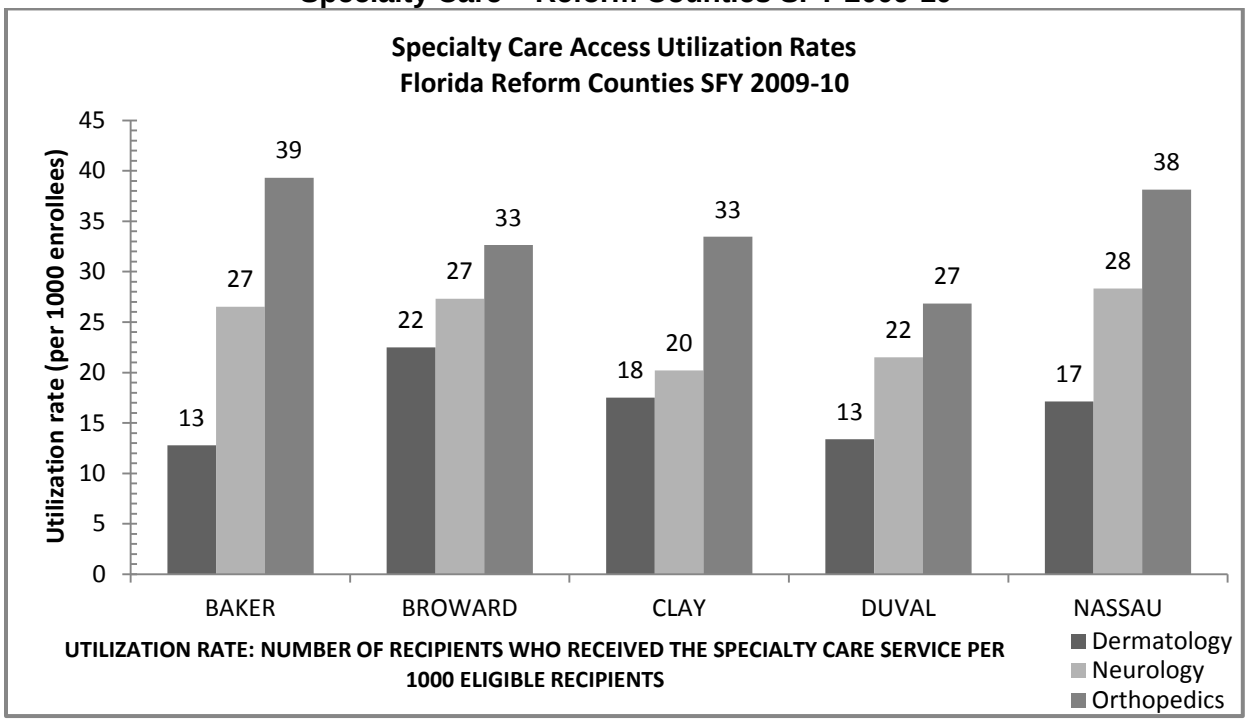


Chart D
Specialty Care – Reform Counties SFY 2010-11

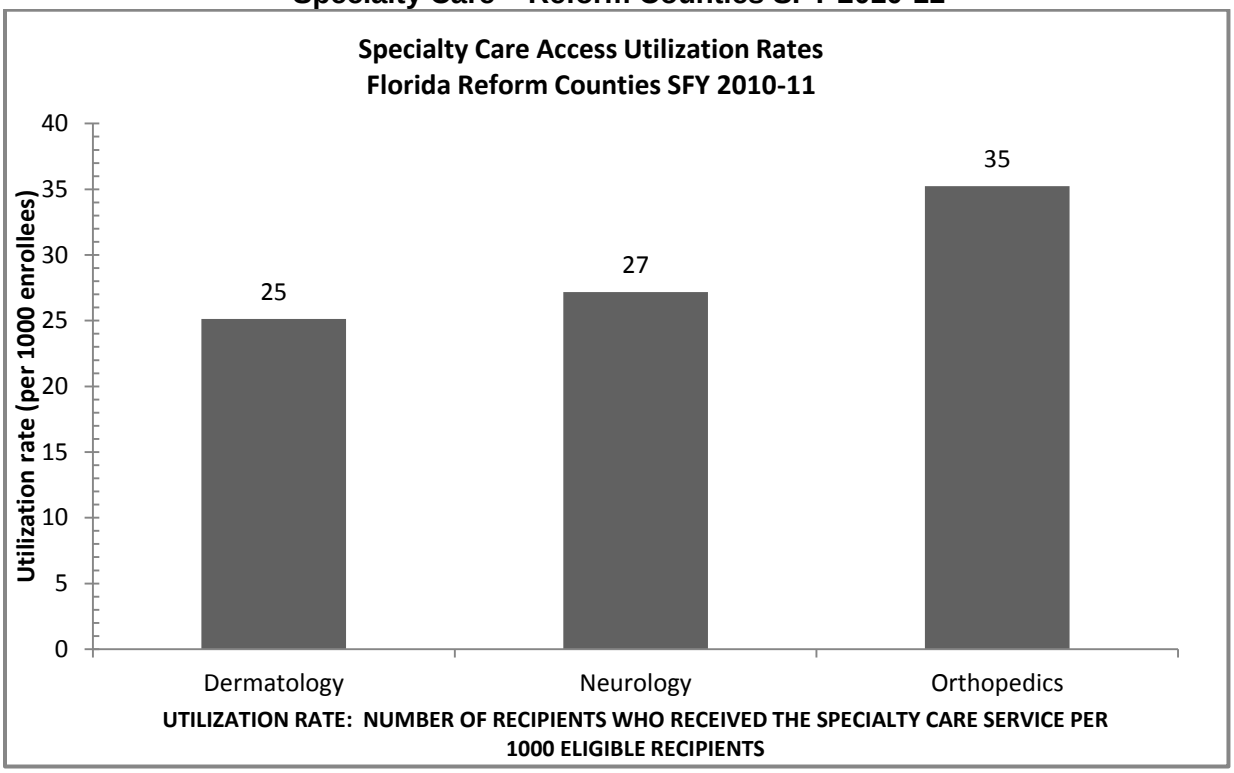


Chart E
Specialty Care – Reform Counties SFY 2010-11

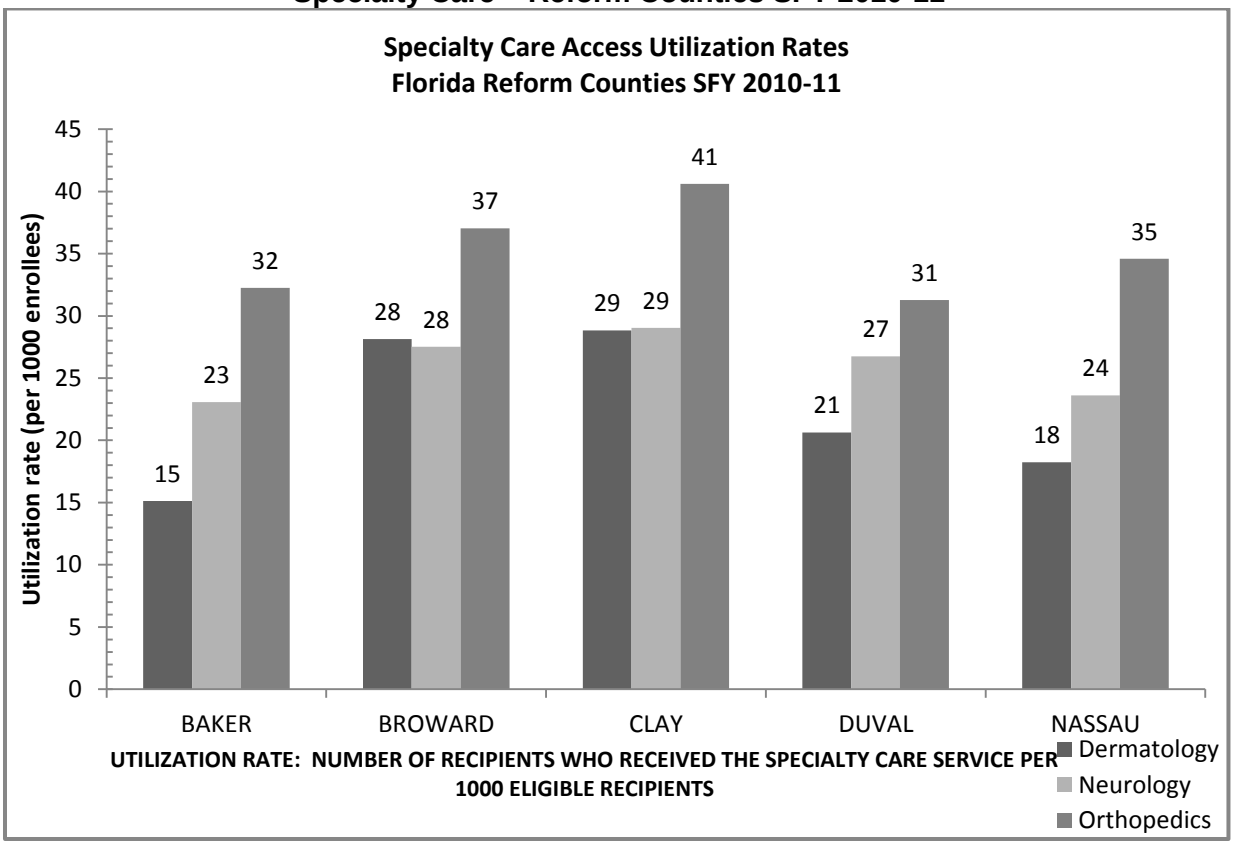


Chart F
Specialty Care – Reform Counties SFY 2011-12

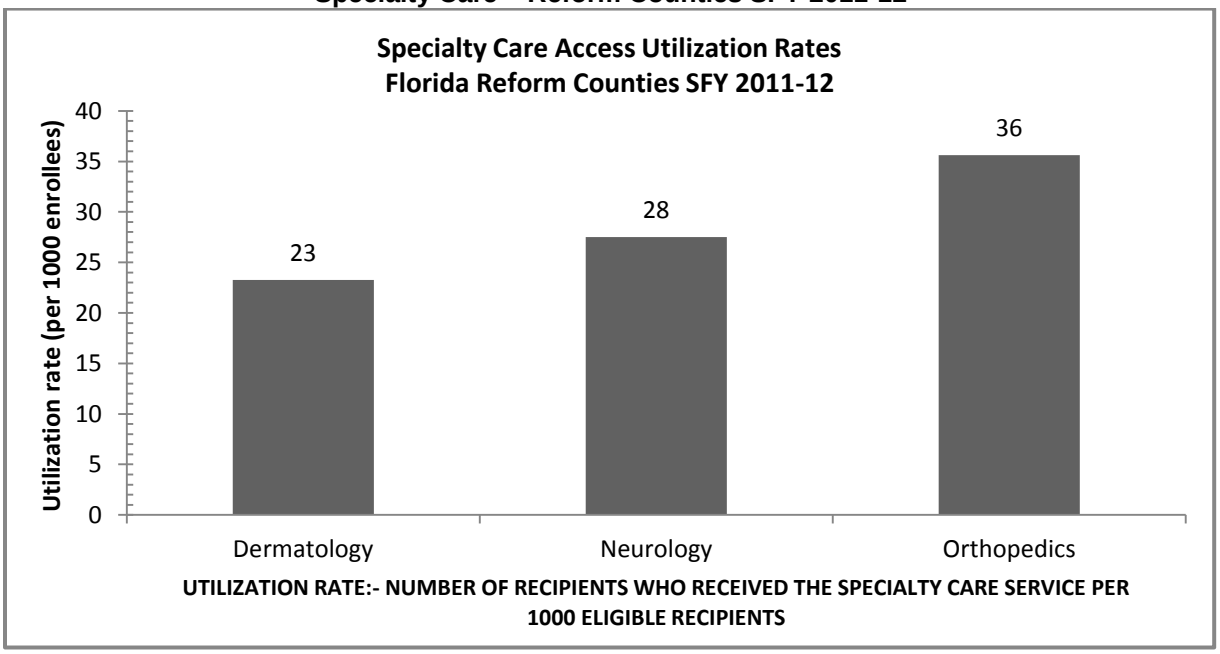
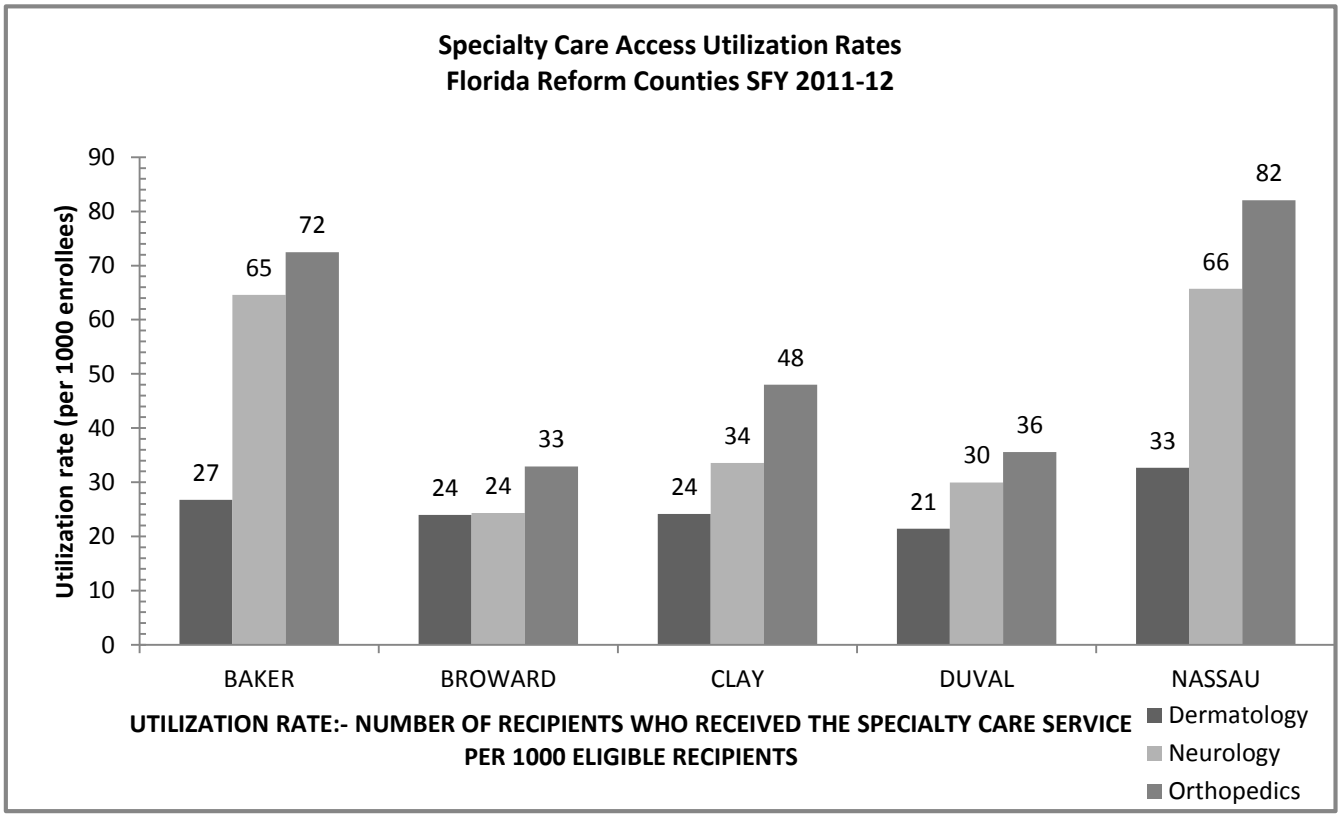


Chart G
Specialty Care – Reform Counties SFY 2011-12



2. Future Efforts

In addition to the ongoing monitoring and assessment of the health plan networks, the Agency will implement new MMA provider network standards that are more thorough than anything Florida Medicaid has required previously, as provided in Table 10 of this document. The Agency drew these standards from Medicare with input from providers statewide including pediatric providers particularly Miami Children's Hospital and All Children's Hospital. Under the MMA program, the Agency intends to validate and verify these networks through a provider network verification process that the plans will be required to update weekly so that potential enrollees have the most up-to-date network information available when selecting a plan. The Agency will continue its monitoring efforts to ensure providers listed as network providers actually participate in the plan's network.

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

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

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

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

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

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

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

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

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

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

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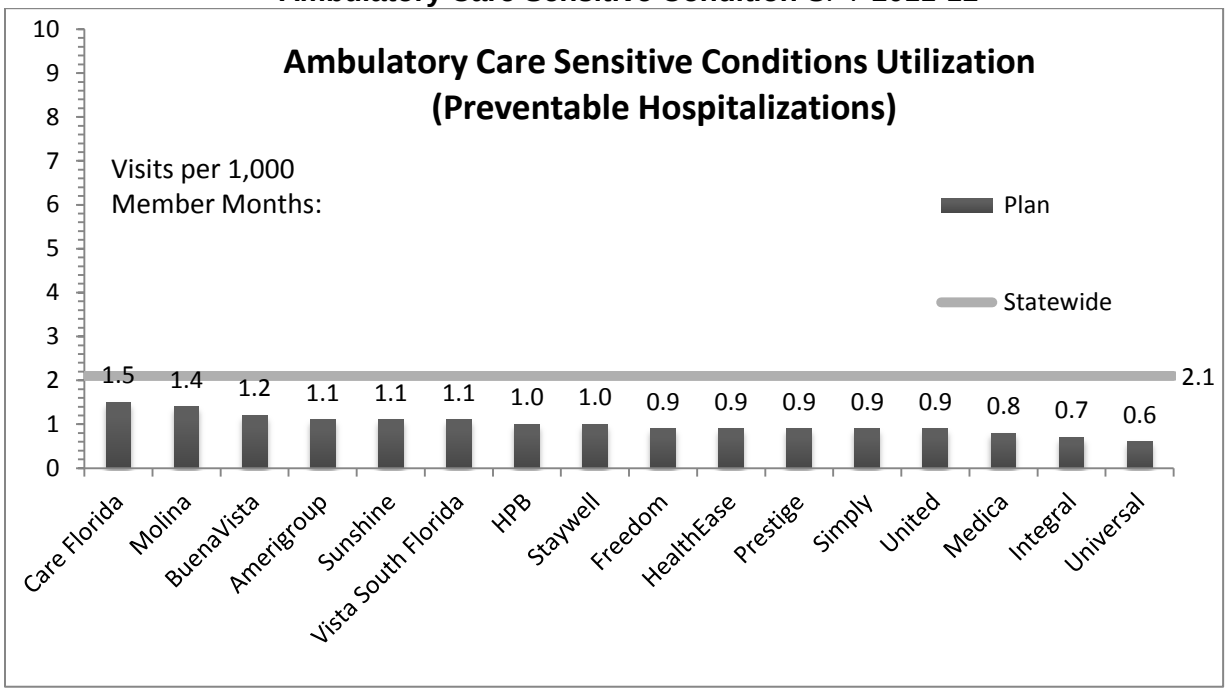
Chart H
Plan Performance Measures
Ambulatory Care Sensitive Condition SFY 2011-12



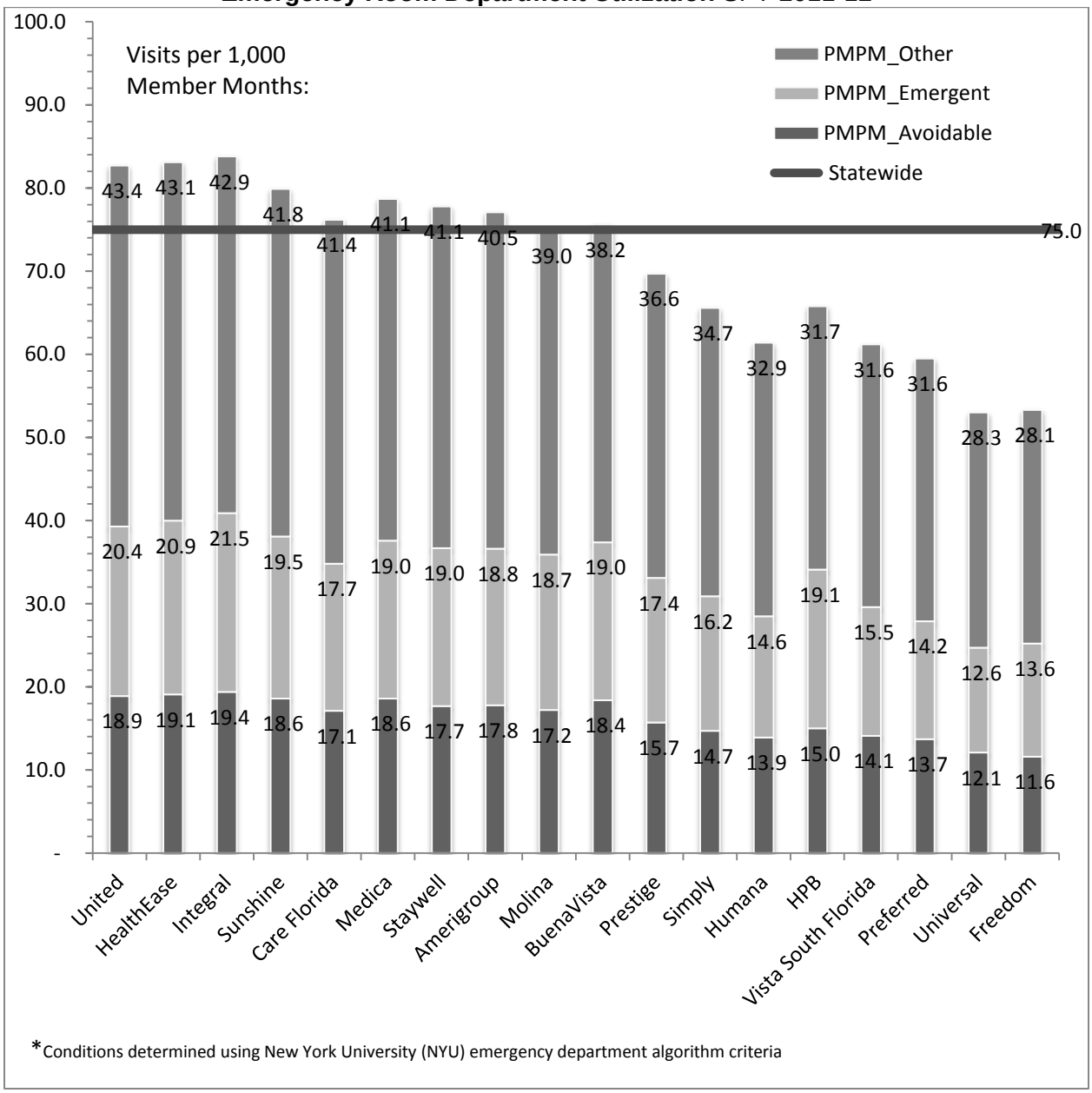
(3)(c) Decreased utilization of emergency room care.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Number of Uninsured and Underinsured Individuals Served

Hospital Providers

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

Non-Hospital Providers

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

b. Summary

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

B. Future Program Objectives

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

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

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

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

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

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

V. Budget Neutrality

A. Budget Neutrality Compliance

The Agency is required to provide financial data demonstrating the detailed and aggregate, historical and project budget neutrality status for the requested waiver extension period (July 1, 2014 to June 30, 2017) and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the Federal CMS Financial Management standard questions. The following addresses the items specified above and documents that the waiver is budget neutral.

1. General Budget Neutrality Requirements

A requirement of any 1115 Research and Demonstration Waiver is that the program must meet a budget neutrality test and provide documentation that the demonstration did not cost the program more than would have been experienced without the waiver. In addition, prior to an extension of the waiver, a projection and extension of new budget neutrality benchmarks using rebased trends must be provided for the requested waiver extension period.

The established STCs of the waiver, as agreed upon by the state and Federal CMS, are provided in the approved waiver document. To comply with the STCs, the Agency must pass the budget neutrality "test", as well as provide quarterly reporting of the expenditures and member months for the waiver, which is used to monitor the budget neutrality. Florida's Research and Demonstration Waiver is budget neutral and is in compliance with all STCs specific to budget neutrality.

2. Budget Neutrality Results To Date

Table 11 located on the following page provides cumulative expenditures and case months for the reporting period for each demonstration year. The combined Per Capita Cost per Month (PCCM) is calculated by weighting Medicaid Eligibility Groups (MEGs) 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months. Since inception of the demonstration through Demonstration Year 7, expenditures have been $15.8 billion less than the authorized budget neutrality limit. As a result, the state is in substantial compliance with budget neutrality and anticipates that by the end of the demonstration, the amount below the authorized budget neutrality limit will be even greater. Details for each year are provided on the following page.

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

3. Florida's 1115 Research and Demonstration Waiver

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

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

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

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

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

The DY09-DY11 renewal years WOW and WW expenditures also include the costs anticipated from that portion of the CHIP population that will transition to Medicaid. Since this new Medicaid population will occur regardless of this waiver's renewal, this population and its projected costs are identified in both the WOW and WW calculations.

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

MEG 3 was established in the initial waiver application as approved by Federal CMS. The MEG is also referred to as the LIP and is not directly linked to Medicaid eligibility. Expenditures for the LIP program are authorized to provide services to the uninsured and underinsured. Distributions to qualifying providers under the LIP program are determined by the type of facility and services as well as the volume of Medicaid days in addition to allowable uninsured and underinsured expenditures incurred in previous operating years. Payments to providers are not paid through the claims processing system but are lump sum payments made directly to the provider to offset the allowable uncompensated services. The limit for the LIP program is established in the budget neutrality and is reported in accordance with the requirements of the STCs of the waiver specific to budget neutrality. However, the program requirements and monitoring are subject to STCs of the waiver established for the LIP program.

The Agency is seeking to increase funding for the LIP at $4.5 billion annually, for the upcoming waiver extension period of July 1, 2014 through June 30, 2017. Refer to Section V.B for more information regarding the proposed change to the LIP program. The LIP expenditures are not included in the calculation of PMPM for the budget neutrality test.

B. System Access and Transformation Incentive Fund

Since its inception in 2006, the Medicaid Reform (now Managed Medical Assistance Program) waiver has included provision for up to $1 billion annually to fund a Low Income Pool (LIP) program. The LIP program was established and maintained by the state to provide government support to safety net providers, including county health departments and federally qualified health centers, for the purpose of providing coverage to the Medicaid, underinsured, and uninsured populations as well as establishing new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low-income populations. While the LIP program has been a successful element of the demonstration to date, the expected transformative potential of Statewide Medicaid Managed Care and other significant changes in the health care marketplace make this an opportune time to re-design this component of the demonstration to ensure that it continues to play a meaningful role in enhancing the quality of care and health of low-income populations.

Florida proposes to redesign the ongoing Low Income Pool as a “System Access and Transformation Incentive Fund (Incentive Fund)” funded at $4.5 billion annually. Based on the calculations provided in the preceding section, this annual amount can be accommodated within the budget neutrality structure and still produce overall system savings. The non-federal portion of the funding for this program component is expected to be provided through voluntary contributions from counties, municipalities, public hospitals, and special taxing districts. The proposed Incentive Fund will have two primary components: a Quality Enhancement Pool and System Transformation Awards. Funding will be allocated between the two components as shown in the following table.

Renewal Demonstration Year	Access Enhancement Pool	System Transformation Awards
DY 09 (July 2014 – June 2015)	85% ($3.825 billion)	15% ($0.675 billion)
DY 10 (July 2015 – June 2016)	70% ($3.15 billion)	30% ($1.35 billion)
DY 11 (July 2016 – June 2017)	60% ($2.70 billion)	40% ($1.80 billion)

The Quality Enhancement Pool (QEP) will be targeted toward providers that have consistently participated heavily in serving Medicaid and low-income populations, and may also include other areas of particular access challenge. Participation in the QEP would require certain threshold activities that further federal and state health delivery system goals, such as successful contracting with Medicaid managed care plans and participation in Event Notification Service activities. Funds would be distributed based on a federally-approved logic that acknowledges both the particular financial challenges faced by providers that serve predominantly low-income populations and the linkage with local funding sources (i.e., reflects the principle that providers in a local area should not receive less than if they were to receive the funding directly from their local governments). Funding received through the QEP would be subject to any applicable provider cost limits.

The second Incentive Fund component, System Transformation Awards, will be designed to support and reward collaborative projects that address particular aspects of service delivery that affect Medicaid recipients and other low-income Floridians. As described in Section II.D, Florida has incorporated a number of new elements in its contracts with managed care plans designed to drive improvement in key service delivery areas. System Transformation Awards will complement those efforts and amplify gains through the use of provider infrastructure funding and financial incentives for success. In particular, these awards will target areas in which significant improvement requires coordinated activities among multiple actors in the health care system, and a traditional approach does not align focus or incentives. The hypothesis to be tested is that a coordinated, concentrated funding opportunity applied to a limited number of critical care delivery areas and carefully balanced between upfront funding and outcome-based financial rewards, can produce significant gains in improving care delivery. Critical to the success of this program will be selecting a manageable number of focus areas, recruiting all key actors in each focus area, and ensuring consistent monitoring and measurement of success. It is expected that most of these focus areas will be multi-year efforts, and improvements will build over time. Outcome measures used for incentive payment will reflect that design as appropriate. The gradual shift of monies between the two Incentive Fund components over the course of the renewal period reflects both the timing needed to implement System Transformation Awards, as well as the fact that the outcome-based financial incentives will not be applicable until the second or third year. Due to the nature of the activities associated with these awards, funding received through this process would not be subject to provider cost limits.

Some examples of potential focus areas for the System Transformation Awards program are “improving timeliness and appropriate setting for care,” emphasizing improved coordination between hospitals and ambulatory care providers, county health departments and federally qualified health centers, to ensure that potentially preventable events (PPEs) are reduced and discharge planning and follow-up are effective at lowering readmission rates; initiatives to improve health outcomes for persons with HIV/AIDS; and more general population health partnerships that emphasize obesity or smoking mitigation.

PPEs attempt to integrate the positive elements of both risk-adjusted prospective payment that began with DRGs in the 1980s and coordinated care networks that were revolutionized by managed care plans during the 1990s. "PPEs" is an umbrella phrase that more specifically encompasses the following: potentially preventable admissions (PPAs), potentially preventable readmission (PPRs), potentially preventable complications (PPCs), potentially preventable emergency room visits (PPVs), and potentially preventable ancillary services (PPSs). Given their design, PPEs are quality metrics--with the potential to be used for cost controls if linked to payment incentives--best suited for evaluating hospitals (the historic participants in LIP), managed care plans (the central functionaries under the new SMMC program), and entities

such as accountable care organizations that are essentially hospital-managed care plan hybrids.

Another example of a critical focus area for the System Transformation Awards program is improving birth outcomes. Florida Medicaid pays for over 50% of births in Florida. A recent March of Dimes report on premature births graded Florida a "D," putting the state in the bottom 20% of states in the nation. Florida has committed numerous resources to ensuring babies are born healthy, but problems persist, and outcomes continue to need improvement. The System Transformation Awards program has the potential to bring hospitals, county health departments, federally qualified health centers, Healthy Start Coalitions, and medical schools all working towards the same goals, for which we have also incorporated performance measures and incentives for the Medicaid managed care plans. The Agency and the Florida Department of Health would work together with providers to design specific projects and outcome measures, but such an effort could include converting the Coalitions to follow the Prenatal Plus program model, which engages pregnant women in client-centered counseling to cease smoking and drug and alcohol use, receive proper nutrition, and be treated for psychosocial issues; as well as creating strong connections between Medicaid managed care organizations and the Coalitions to ensure they are partnering in the best interest of their mutual clients. It might also include expansion of the activities of Florida Perinatal Quality Collaborative, which works to improve Florida's maternal and infant health outcomes through the delivery of high quality, evidence-based perinatal care.

Florida expects that certain focus areas will be specifically targeted based on federal and state policy, while provider partnerships will also have the opportunity to propose other focus areas that are aligned with the CMS Three-Part Aim. Again, the key to success will be selection of a manageable number of focus areas, recruiting all key actors in each focus area, and ensuring consistent monitoring and measurement of success.

With the greater funding level of the Incentive Fund and the intense focus on effecting system change and improved outcomes through the System Transformation Awards, meaningful program evaluation is needed to ensure that the program is achieving the desired outcomes and any improvements to program design are identified. To this end, Florida proposes that a small portion of the Incentive Fund be made available to fund an annual evaluation. The state proposes that an evaluation be conducted for each focus area of the System Transformation Grants. The evaluation will include process measures for looking at the activities/ improvements/interventions that are being put into place under these awards, as well as outcome measures to see if the process/infrastructure changes resulted in improved outcomes in terms of quality of care, health status, patient safety, and/or costs. Evaluating the success of the award projects will allow the state to identify which interventions result in real improvements in outcomes. Until the state knows the specific focus areas of the awards, it is difficult to be too specific about the evaluation design.

As a final matter, much has been said in the media regarding this request, and the fact that it increases the $1 billion per year previously disbursed under the LIP program. Florida assures Federal CMS that this request is made to improve the health of Floridians, and this request has no connection to the Medicaid expansion provisions of the Affordable Care Act. Florida will continue to seek this funding regardless of any expansion decision made by Florida's political leadership

C. Financial Management Standard Questions

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

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

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and state share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

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

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

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

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

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

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

   For Florida State Fiscal Year 2013-14, the UPL analysis involves estimating Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. The claim data and hospital Medicare cost data are aligned so that they are from the same time frame. In addition, inflation factors are applied as appropriate to make payment and cost amounts comparable under the same time frame. Also if appropriate, other adjustments may be made to the baseline claim data to align with Medicaid program changes that have occurred between the timeframe of the baseline claim data and the UPL rate year.

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

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

   Estimated Medicare payments which determine the upper payment limit were calculated using a detailed costing method. For each hospital, information extracted from Medicare cost reports were used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. In addition, a mapping of revenue codes to cost centers was created. This mapping allowed a cost center to be identified for each

claim detail line based on the revenue code submitted on the line. Costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. Total costs on all claim lines for a provider were summed to get the UPL amount per provider and then summed by category of provider to get the UPL amount for the three UPL categories, state-owned, non-state government owned, and privately owned (all others).

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

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

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

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VI. Quality Initiatives

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

A. Plan Performance Measures and Improvement Strategies

1. The Waiver from Initiation through the Present

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

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

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

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

Table 12 provides the list of performance measures the health plans were required to report to the Agency on July 1, 2013, for calendar year 2012.

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

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

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

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

Table 13 lists the statewide average results for measures that were submitted from 2008 through 2012, and provides the 2012 National Mean as published by NCQA for the Medicaid product line as a comparison.

Table 13
Florida Medicaid Reform Plan Performance
HEDIS® Measures 2008-2012

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

Table 13 Florida Medicaid Reform Plan Performance HEDIS® Measures 2008-2012						
Measure	2008	2009	2010	2011	2012	2012 National Mean
Adults' Access to Preventive Care – total	n/a	77.2%	77.6%	77.0%	75.0%	81.8%
Antidepressant Medication Mgmt – Acute	n/a	52.0%	56.3%	56.3%	57.4%	51.1%
Antidepressant Medication Mgmt – Continuation	n/a	29.8%	43.8%	44.0%	43.1%	34.4%
Appropriate Medications for Asthma	n/a	83.6%	87.6%	86.0%	81.1%	85.0%
Breast Cancer Screening	n/a	51.4%	56.9%	59.2%	52.3%	50.4%
Childhood Immunization Combo 2	n/a	63.6%	70.0%	74.0%	74.8%	74.5%
Childhood Immunization Combo 3	n/a	53.8%	62.7%	66.9%	69.2%	70.7%
Frequency of Prenatal Care	n/a	52.6%	46.9%	44.0%	54.4%	60.9%
Lead Screening in Children	n/a	54.8%	52.0%	54.1%	59.6%	67.7%
Adult BMI Assessment	n/a	n/a	41.9%	52.7%	47.9%	52.6%
Follow-up Care for Children Prescribed ADHD Medication – Initiation	n/a	n/a	43.6%	44.5%	44.4%	38.8%
Immunizations for Adolescents – Combo 1	n/a	n/a	44.1%	43.6%	47.3%	60.4%

Of the 30 HEDIS® measure rates presented in Table 13, the statewide average results for the Reform plans improved by at least one percentage point for 14 of the measures, compared to the previous year. Non-Reform plans' rates for 11 of the measures stayed about the same, while their performance on seven of the measures dropped.

Performance measures with notable improvement include:

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

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

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

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

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

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

Health plans are also required to submit performance measure data for their populations outside of the waiver. Table 14 compares the Reform and non-Reform plans' statewide average performance on HEDIS® measures reported in 2012. Again using statewide average data, the Reform health plans outperformed non-Reform health plans in 19 of 30 measure rates.

Table 14
2012 Reform Measures Compared to Non-Reform Measures

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

Table 14 2012 Reform Measures Compared to Non-Reform Measures			
Plan Performance Measures	**2012 Non-Reform**	**2012 Reform**	**Difference**
Well-Child First 15 Months – Zero Visits (INVERSE)	3.2%	2.1%	1.1%
Well-Child First 15 Months – Six Visits	56.2%	58.4%	2.2%
Well-Child 3-6 years	75.6%	75.5%	*
Adults' Access to Preventive Care – total	69.9%	75.0%	5.1%
Antidepressant Medication Mgmt – Acute	50.4%	57.4%	7.0%
Antidepressant Medication Mgmt -- Continuation	33.6%	43.1%	9.5%
Appropriate Medications for Asthma	82.1%	81.1%	*
Breast Cancer Screening	50.1%	52.3%	2.2%
Childhood Immunization Combo 2	79.1%	74.8%	*
Childhood Immunization Combo 3	72.8%	69.2%	*
Frequency of Prenatal Care	60.2%	54.4%	*
Lead Screening in Children	59.5%	59.6%	0.1%
Adult BMI Assessment	58.6%	47.9%	*
Follow-up Care for Children Prescribed ADHD Medication – Initiation	40.8%	44.4%	3.6%
Immunizations for Adolescents – Combo 1	56.1%	47.3%	*

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

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

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

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

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

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

2. Looking Forward to Implementation of the MMA Program

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

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

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B. Summary of EQRO Reports

1. External Quality Review Activities

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

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

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

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

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

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

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

2. Validation of Quality Initiatives

a. <u>Validation of Performance Improvement Projects</u>

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

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

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

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

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

Table 15 provides summary information on the percentage of HMO and PSN collaborative and non-collaborative PIPs met for SFY 2012-13.

Table 15
Performance Improvement Project Validation Results
SFY 2012-2013

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

b. Validation of Performance Measures

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

c. Strategic HEDIS® Analysis Report

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

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

Focused Study Quality Initiative: Emergency Department Collaborative

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

Some of the accomplishments of the Emergency Department Collaborative included:

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

C. Enrollee Satisfaction Surveys and Choice Counseling Caller Satisfaction Survey

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

1. Consumer Assessment of Health Care Providers and Systems

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

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

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

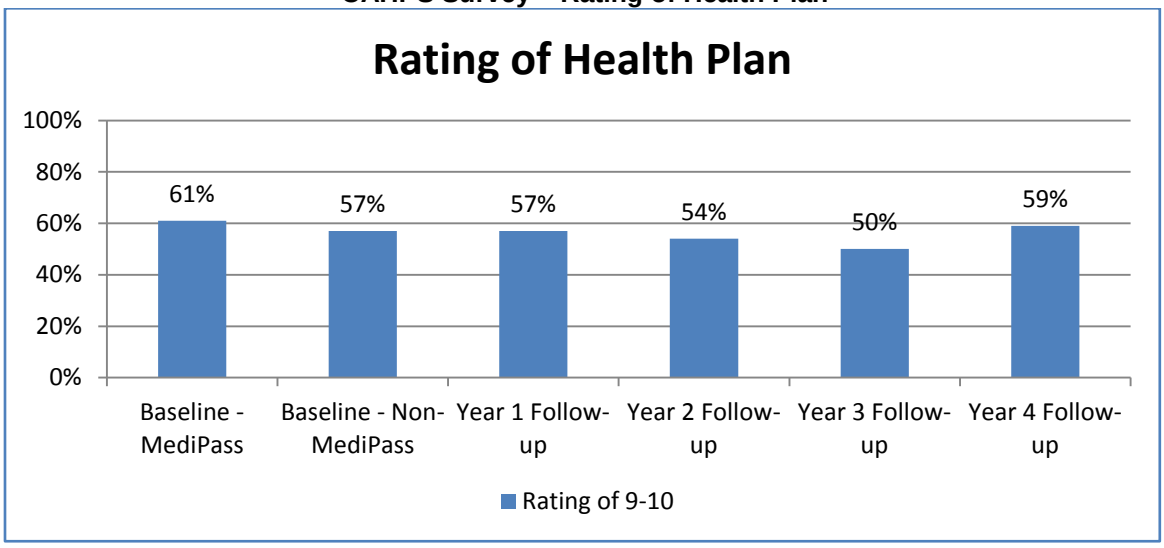
The multiple rounds of survey findings provide interesting and not entirely consistent trends. For example, while ratings of health plan satisfaction decreased in the first three follow-up years compared to Baseline, health plan satisfaction increased in the fourth follow-up survey, to approximately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

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

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

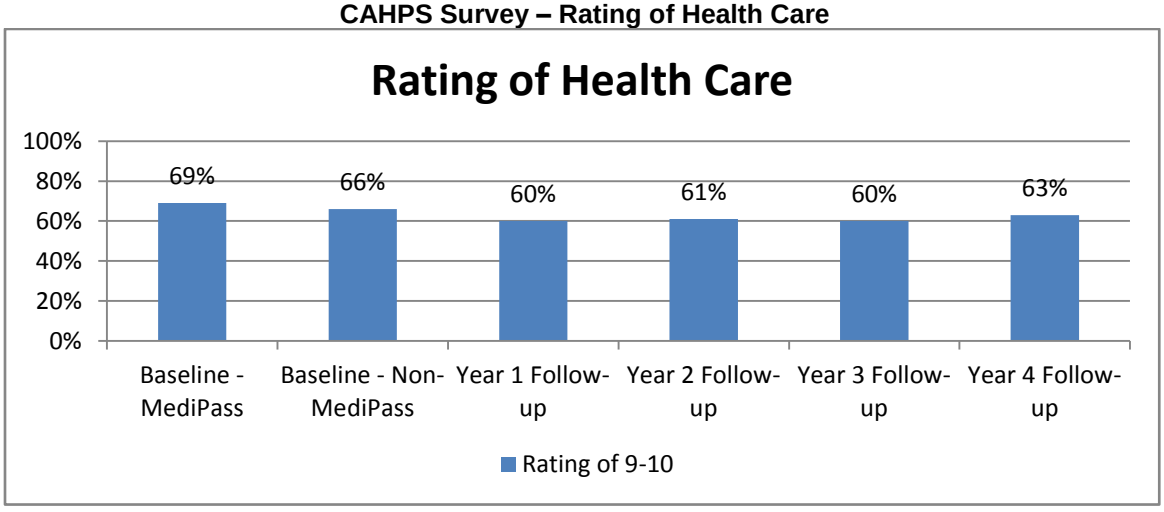
The CAHPS survey asks enrollees to rate their health plan on a scale from 0 to 10, with 0 being the worst plan possible and 10 being the best plan possible. At baseline, 61% of MediPass enrollees and 57% of Non-MediPass enrollees rated their health plan a 9 or a 10. The percentage of Reform plan enrollees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

Chart J
CAHPS Survey – Rating of Health Plan



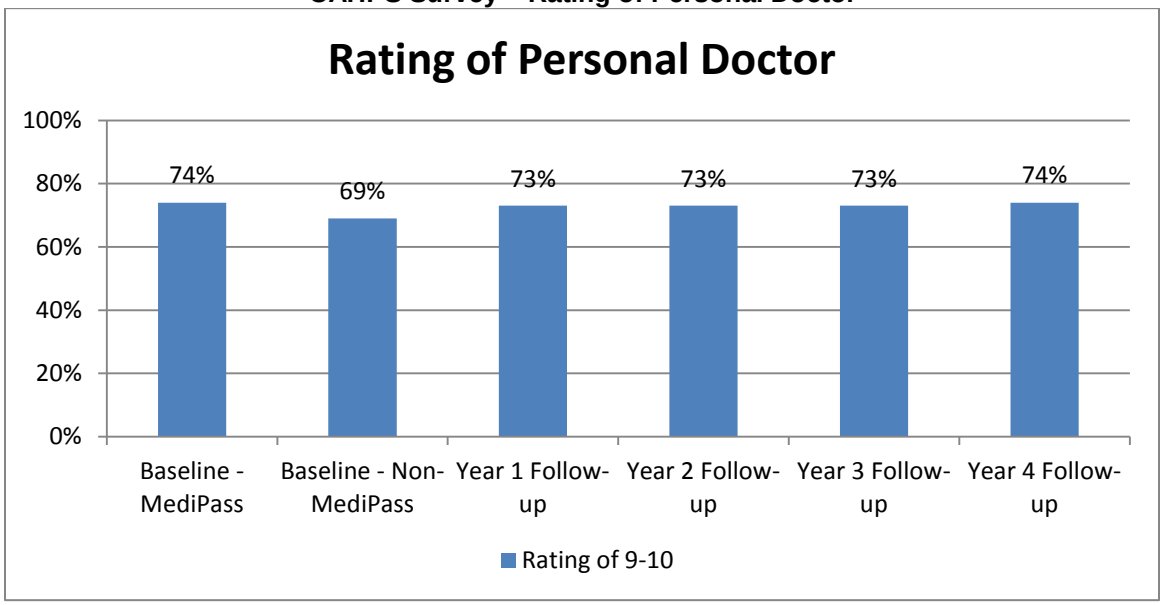
CAHPS survey respondents are asked to rate their health care on a scale of 0 to 10, with 0 being the worst care possible and 10 being the best health care possible. At Baseline, 69% of MediPass enrollees and 66% of Non-MediPass enrollees rated their health care a 9 or 10. The percentage of Reform plan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

Chart K
CAHPS Survey – Rating of Health Care



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

Chart L
CAHPS Survey – Rating of Personal Doctor



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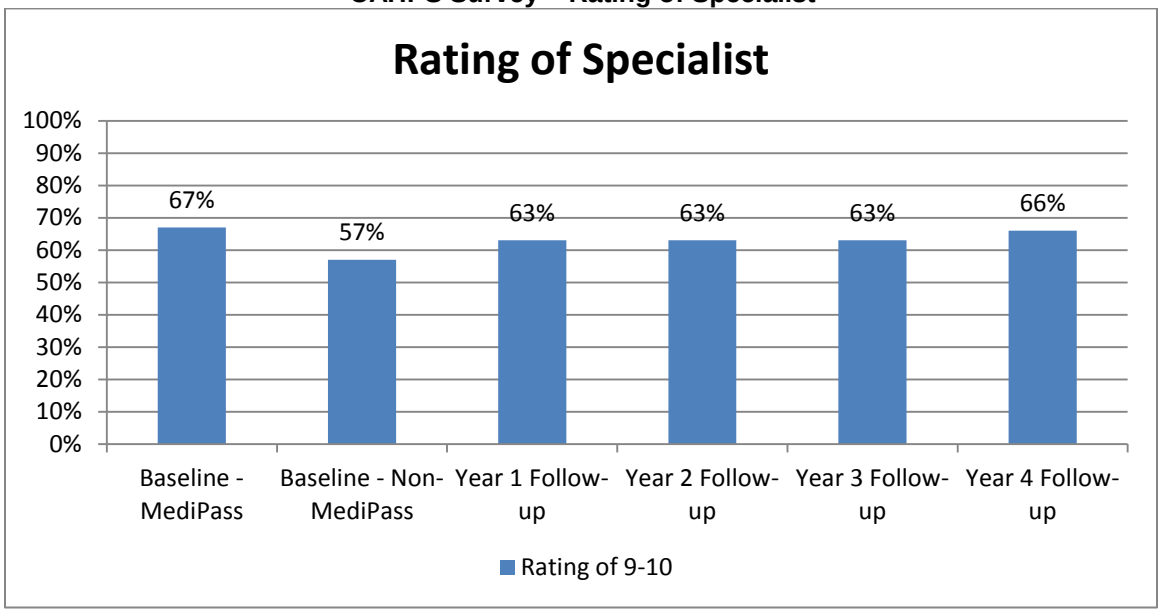
The CAHPS survey also has enrollees who have seen a specialist rate their specialist on a scale from 0 to 10, with 0 being the worst possible specialist and 10 being the best possible specialist. At Baseline, 67% of MediPass enrollees and 57% of Non-MediPass enrollees rated their specialist a 9 or 10.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

Chart M
CAHPS Survey – Rating of Specialist



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

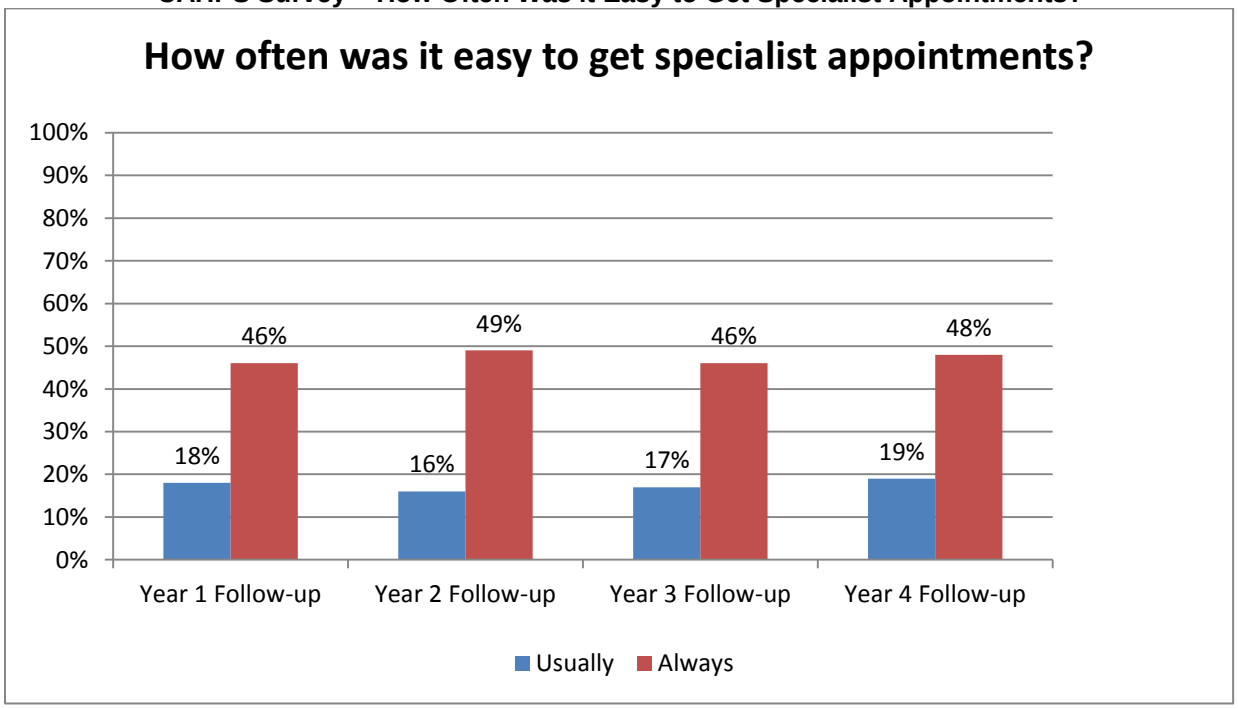
In the Baseline and Year 1 through 4 follow-up surveys, enrollees were asked about ease of getting specialist appointments and getting care, tests, or treatment needed through the respondent's health plan. The wording and orientation of these survey items changed from the Baseline to the follow-up surveys,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

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

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

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

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



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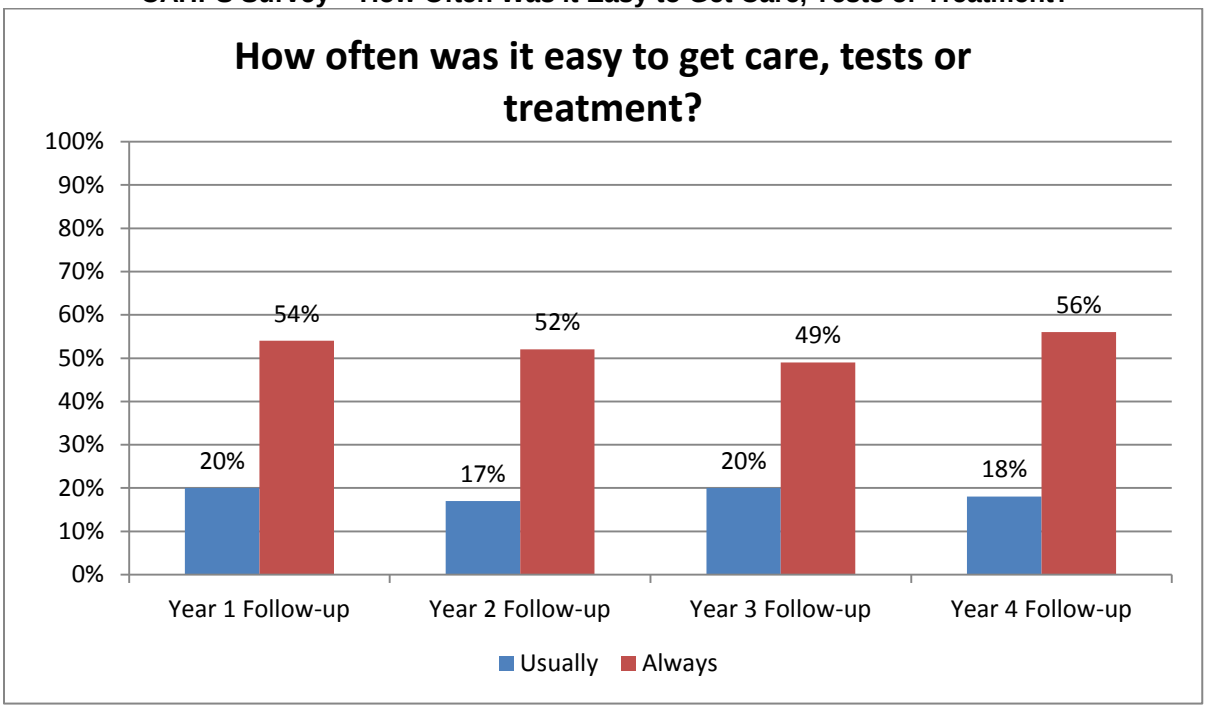
At Baseline, 72% of MediPass enrollees and 69% of Non-MediPass enrollees said it was “not a problem” to get the care, tests or treatment they or a doctor believed necessary. In the Year 1 through Year 4 follow-up surveys, the percentage of Reform plan enrollees reporting it was “always” easy to get the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

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



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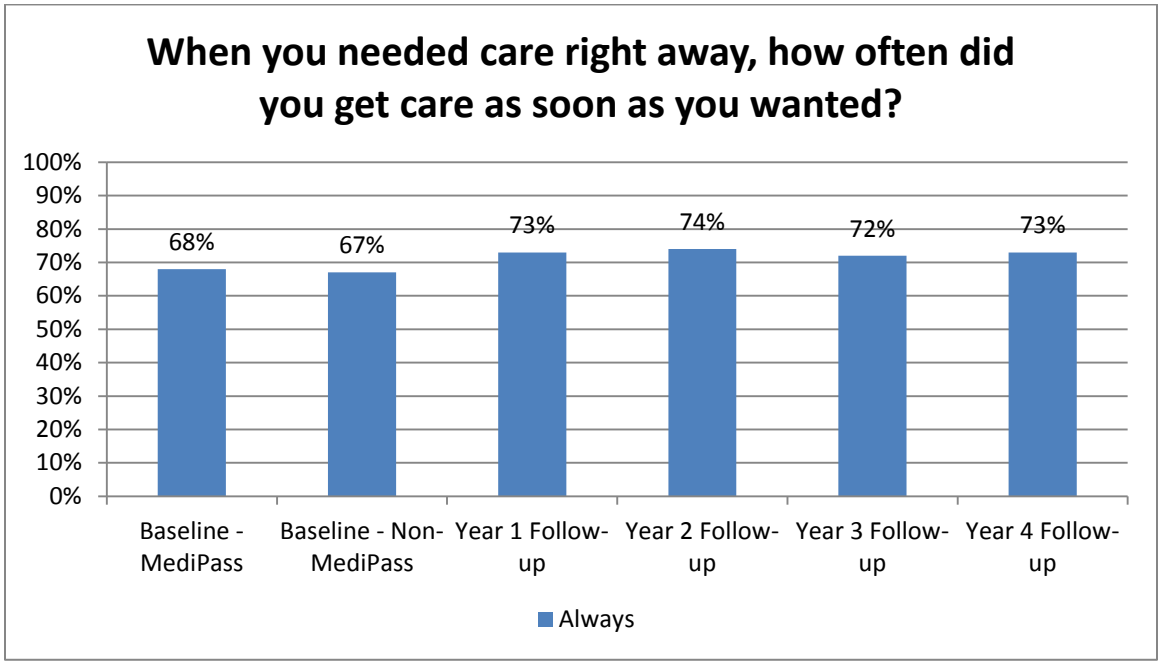
c. Getting Care when Needed: Urgent Care and Non-Urgent Care

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

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



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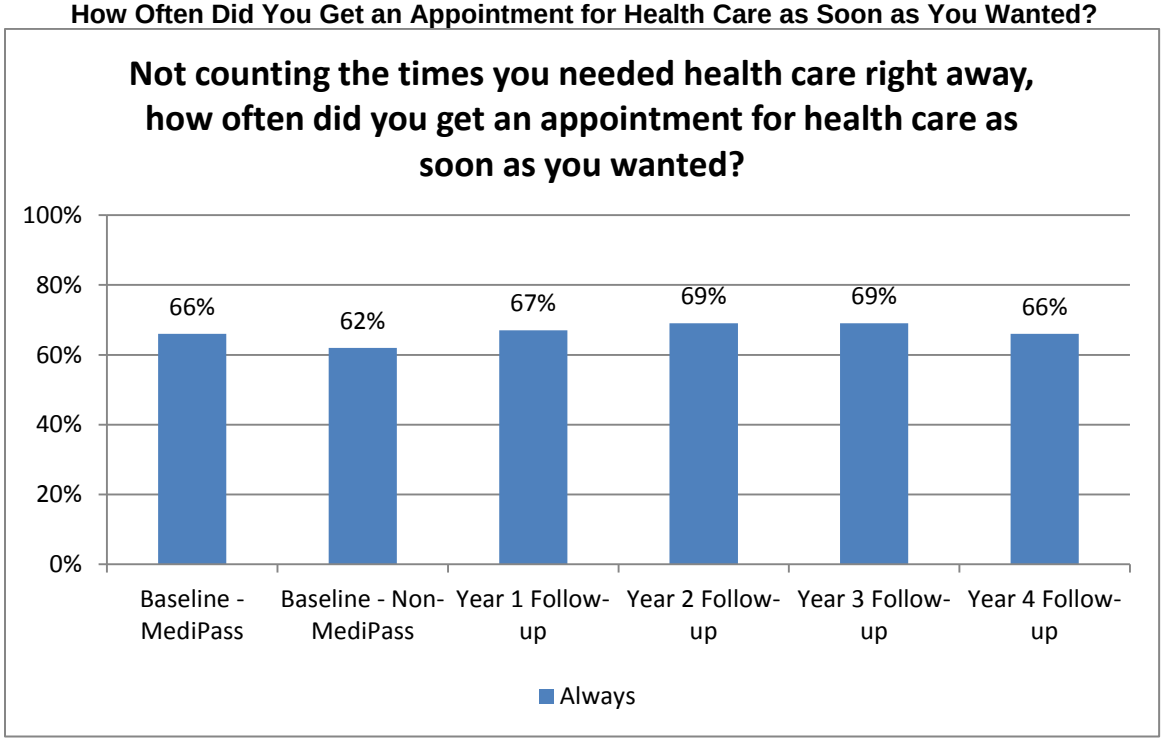
Survey respondents were also asked how often they got appointments for health care as soon as they wanted, not counting the times they needed health care right away. At Baseline, 66% of MediPass enrollees and 62% of Non-MediPass enrollees reported that they "always" got an appointment as soon as they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

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



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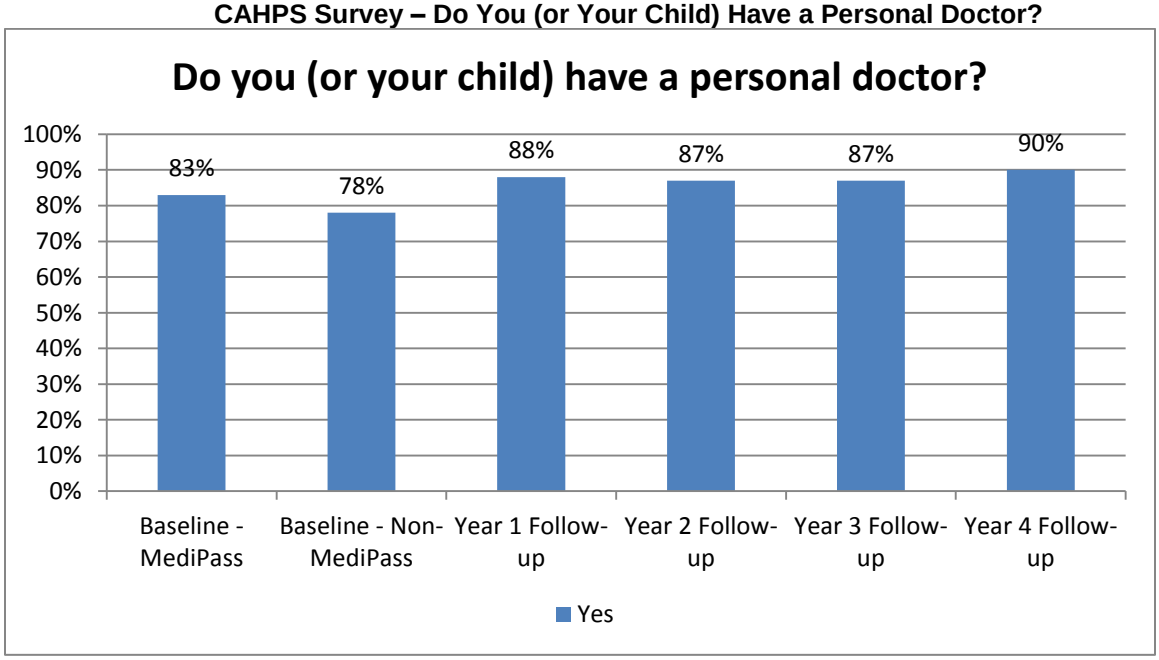
d. Having a Personal Doctor

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

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



2. Future CAHPS Survey Activities

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

3. Choice Counseling Caller Satisfaction Surveys

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

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

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

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

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

D. State Quality Assurance Monitoring

1. On-Site Surveys

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

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

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

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

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

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

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

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

Under the 2012 compliance survey, six HMOs and two PSNs were given a required Action for the following contract requirement: Section IV, A, 11. g, of the Health Plan Contract, the Health Plan shall have an automated system available between the hours of 7:00 p.m. and 8:00 a.m., in the enrollee's time zone, Monday through Friday and at all hours on weekends and holidays. This automated system must provide callers with clear instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for caller to leave messages. The

Health Plan shall ensure that the voice mailbox has adequate capacity to receive all messages. A Health Plan representative shall respond to all messages on the next business day.

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

2. Ongoing Desk Reviews

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

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

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

3. Annual Document Review

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

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

Disease management is also reviewed. Each health plan is required by contract to offer disease management programs for at least five conditions: HIV/AIDS, asthma, diabetes, congestive heart failure and hypertension. The specialty plan for recipients living with HIV/AIDS must also offer disease management for tuberculosis and hepatitis B and C. All initial health plan applicants complied with these requirements in 2006, and submitted their programs as a part of their initial reviews. All plans have been submitting them annually by April 1. The health plans have taken varied methods to comply with these requirements. Some plans have in-house disease managers and very structured programs for each of the referenced diseases. Other plans have chosen to have an over-arching disease management algorithm that narrows the focus for the individual member as the evaluation is done. The health plan disease managers monitor their plan's disease management programs through the individualized treatment plans

that are tailored to meet the needs of the recipient. Still other health plans have chosen to outsource to disease management companies. When the programs are outsourced, the Agency evaluates the health plan's incorporation of oversight into their Quality Improvement Program. The only exception is the specialty plan for children with chronic conditions. This specialty plan's entire program is geared toward disease management of children and is very individualized. Members are not eligible for this program unless they meet pre-determined clinical screening criteria. Once a child is enrolled, he or she is assigned to a nurse care coordinator who works with him or her throughout his or her enrollment to ensure individualized and highly specialized disease and case management.

4. Readiness Review Preparation for MMA Program

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

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

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

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

E. CMS 416 Report

The Federal CMS 416 report is due to Federal CMS on April 1 of each year. To increase the accuracy of the report and avoid duplication, the Agency worked with Federal CMS to refine the Agency's data collection process to eliminate potential duplication of eligible recipients in the reported data by comparing FFS claims and encounter data.

During this demonstration period, the Agency took action to increase access to preventive services for children enrolled in managed care as well as to increase the accuracy of reporting. The Agency accomplished this by placing the current health plans an action plan related to the child health checkup screening and participation rates. The plans, by Agency contract and state law, must achieve a child health checkup screening rate of at least sixty percent for those members who are continuously enrolled in the plan for at least eight months. In addition, the plans must achieve at least an eighty percent child health checkup screening participation rate. The plans have submitted their action plans and are being monitored for compliance.

F. Additional Quality Activities

1. Continuous Improvement Activities

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

The Agency has made many improvements in the Reform program and applied those to the entire state so that all Medicaid recipients and providers can benefit from these accomplishments. Table 16 provides a detailed list of the more notable quality improvement activities that the Agency has been involved with that stems from the waiver and lessons learned through public input, workshops, team efforts and forums.

Table 16
Continuous Quality Improvement Activities

Health Plan Communication Activities

- Technical and operational calls with all Medicaid health plans on a regular basis, at least monthly.
- Technical assistance calls with FFS PSNs and their third party administrators regarding Medicaid fiscal agent processes, including claims, file submission and reports, at least monthly.
- Quarterly technical assistance meetings with health plans related to fraud and abuse initiatives.
- Technical assistance webinars with health plans related to fraud and abuse training.
- Technical assistance calls and meetings with health plans related to implementation of Diagnosis-Related Group coding initiative.
- Technical assistance calls and meetings with health plans related to implementation of Affordable Care Act requirements including 2013 and 2014 physician fee increase to Medicare rates for certain primary care physicians and procedures and coverage restrictions for provider preventable conditions.
- Technical assistance calls with new health plans to assist in implementation of the contract, recipient enrollment and to ensure communication to all affected parties regarding the new plan.
- Focus group with plan applicants and new contractors to request input on what worked and was cumbersome in the health plan application process in order to streamline the application process and better serve potential contractor needs.
- Technical assistance calls with health plans and plan applicants to collect input on revisions to the model health plan contract for 2012-2015 contract period.
- Technical assistance calls with health plans and applicants to collect input on the development and

Table 16
Continuous Quality Improvement Activities

implementation of the electronic Report Guide companion to the model health plan contract for 2012-2015 contract period.

- Continuous improvement meetings with the health plans to collect input into various processes related to implementation of the waiver, including outreach, systems, claims processing, etc.
- Technical assistance and review calls with health plans regarding their provider network accuracy.
- Technical assistance calls with affected health plans when plans leave a county or transition populations due to acquisition or assignment.
- Technical assistance calls with health plans related to collection of Medicaid encounter data.
- Technical assistance calls and meetings with health plans and the EQRO vendor relative to performance improvement plans, at least quarterly.
- Technical assistance calls with health plans regarding the development of and implementation of performance measures, required performance measure objectives, related corrective action process, sanctions and incentives.
- Technical assistance calls relative to enhanced benefits program.
- Technical assistance calls relative to enhancements to the choice counseling program.
- Technical assistance calls relative to data used for capitation rate development.
- Included affected providers on technical and operational calls with the health plans to discuss implementation issues. Such providers included prescribed pediatric extended care providers and the Department of Health.
- Written communications regarding contract policy and procedures to ensure contract compliance.
- Written communications regarding phase-out of the enhanced benefits program with the implementation of the Healthy Behaviors programs to be operated by the plans under the MMA program.

Health Plan Application and Contract Revisions

- Streamlined the health plan contract to eliminate duplicative contract requirements and reporting and incorporating an electronic Report Guide that provides health plans with the detailed information necessary to develop and submit contract required reports.
- Added the imposition of liquidated damages in the event of a health plan's breach of contract requirements.
- Added requirements to ensure implementation of the Affordable Care Act 2013 and 2014 physician fee increases to Medicare rates for certain primary care physicians and procedures and to ensure coverage restrictions for provider preventable conditions.
- Added additional plan performance measure reporting, implementing performance measure objectives, corrective action plan and sanction requirements and incentives for high performance.
- Added additional critical incident reporting requirements.
- Added claims processing, submission, provider notification and reporting requirements for FFS PSNs.
- Added the ability, upon Agency approval, to provide certain services through telemedicine.
- Added Medicaid encounter data submission and accuracy requirements and sanctions for poor performance.
- Added requirements to ensure a seamless transition from ICD-9 codes to the new ICD-10 codes and to reflect the coding changes brought about by the transition.
- Added the following specialties to the required provider list, including required availability of both adult and pediatric participating providers:
  - Adolescent Medicine,

Table 16
Continuous Quality Improvement Activities

- Cardiovascular and Orthopedic Surgery,
- Rheumatology and
- Speech Therapy.

- Revised behavioral health reporting requirements to streamline audits for ongoing health plans in good status.
- Added requirements relative to fraud and abuse detection, reporting and policies and procedures in order to ensure appropriate plan activities and oversight.
- Added marketing and community outreach requirements.
- Added an optional ability for health plans to notice enrollees on upcoming Medicaid eligibility redetermination dates.
- Enhanced requirements regarding the provision of information to enrollees about how to update mailing and/or residence address information with the health plan and through Florida Department of Children and Families and/or the Social Security Administration.
- Added requirements for 120-day notice and enrollee transition plan requirements when a health plan leaves a county.
- Added additional Agency monitoring relative to health plan websites, provider networks and directories, fraud and abuse and quality initiatives, such as performance measures.
- Contracted with EQRO for development of an automated on-site health plan survey tool to ensure consistency of reviews and standardized scoring.
- Implemented quarterly contract oversight review meetings between various Agency bureaus responsible for oversight of some aspect of the health plan contract, including changes in plan management, on-site and desk reviews regarding provider networks, general medical health care behavioral health, fraud and abuse and reporting.

Consolidated Web-based Complaint Reporting and Tracking System

- Conducted workgroup meetings and conference calls with Agency headquarters and local agency staff relative to development of a web-based system for health plan complaint reporting and tracking.
- Implemented a consolidated complaint database for the collection of complaints received about health plans by the Agency either at a headquarters location or local area office location and automated referrals to the appropriate Agency office responsible for resolution.
- Developed a standard complaint definition, reporting process and training manual for staff to handle, disseminate, resolve and track complaints received about health plans using the consumer issues report system.
- Developed quarterly trend reports and conducted meetings to review such trends to ensure attention to any atypical results.

Legislatively Mandated Advisory Panels

- Low Income Pool Council – LIP Council meetings, held several per year, to advise the Agency, the Governor and the Florida Legislature on financing and distributions of the LIP.
- Technical Advisory Panel – Technical Advisory Panel meetings, at least quarterly, to advise the Agency on various aspects of the waiver, including choice counseling, enhanced benefit program, risk-adjusted capitation rates and encounter data.
- Medical Care Advisory Committee – The MCAC meets at least three times a year and provides advice on various aspects of the waiver.

2. Florida Medicaid Encounter Data

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

With the movement from a FFS provider reimbursement system to statewide managed care delivery system, about 87 percent of the Florida Medicaid population will be enrolled in managed care, which will significantly increase the volume of encounter claims to be collected and validated in the foreseeable future. Continuous improvement activities foster the refinement of the fiscal agent operations and transaction processing. Agency's efforts to provide continuing support and to work with the health plans to make their encounter data submissions more successful include:

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

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

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

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

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

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

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

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

Encounter Data is used to evaluate health plans' performance measures. In the last two fiscal years, reports were presented to the legislature, legislative staff and the health plan association demonstrating four specific examples of measures being conducted through analysis of the data. These specific analyses measured Emergency Department Utilization, Ambulatory Care Sensitive Conditions (ACSC), PCP Utilization and History and Physical 180 (H&P 180). The Agency is refining the performance measure reports to include additional information, such as risk adjusted data. Results are used to communicate deficiencies to the health plans and to identify issues initiating focused analyses by compliance, fraud or program integrity units.

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

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

3. Low-Income Pool Quality Initiatives

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

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

STC #62 specifies that the initiatives will focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities must implement new, or enhance existing, health care initiatives, investments, or activities with the

goal of meaningfully improving the quality of care and the health of populations served (including low income populations) and meet established hospital specific targets, to receive 100 percent of allocated LIP funding.

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

- Reductions of Surgical Site Infections and Other Surgical Complications
- Reductions of Readmissions (in general and for specific conditions/illnesses)
- Primary Care Expansions and Enhancements
- Sickle Cell Day Treatment Program
- Post-discharge Support Services
- Acute Care at Home
- Emergency Department Diversion
- Reducing No-shows for Physician Appointments
- Enhancement of Patient Centered Medical Homes at Community Health Centers
- Improving Emergency Department Turn-around Time
- Reducing Inpatient Falls
- Improving Birth Outcomes
- Developing and Providing Access to Electronic Health Record Systems
- Improving the Monitoring of Patients with Chronic Conditions through Mobile Technology
- Decreasing Average Length of Stay for Patients with Particular Conditions
- Disease Management Programs and Coordination, for physical and behavioral health
- Reducing the Number of Mislabeled Specimens

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

4. Florida Medical Schools Quality Network

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

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

VII. Evaluation Status and Findings

A. Overview of Independent Evaluation

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

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

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

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

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

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

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

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

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

2. Evaluation of the Extension

a. Current Waiver Extension Period (2011-2014)

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

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

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

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

b. Federally Approved MMA Amendment (June 2013)

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

B. Research Questions and Findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Analyses will include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Reports and Findings to Date

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

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

The DY6 accomplishments that were identified include the following:

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

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

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

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

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

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

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

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

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

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

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

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

6. Pending and Upcoming Evaluation Reports

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

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

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

C. Proposed Evaluation Activities

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

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

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

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

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

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

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

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

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VIII. Special Terms and Conditions of Waiver

The following section documents compliance with the special terms and conditions of the 1115 Managed Medical Assistance waiver approved by the Centers for Medicare and Medicaid on June 14, 2013 in compliance with the transparency requirements 42 CFR 431.412 and the extension requirements specified in STC #9 of the waiver.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00206/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

I. Preface

The following are the Special Terms and Conditions (STCs) for the Florida Managed Medical Assistance Program 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: Program Description and Objectives; General Program Requirements; Eligibility For Medicaid Reform and the Managed Medical Assistance Program; Enrollment; Benefit Packages and Plans in Medicaid Reform and Managed Medical Assistance Program; Cost Sharing; Florida Managed Medical Assistance Program Implementation; IX. Delivery Systems; Consumer Protections; Choice Counseling; Enhanced Benefits Account Program; Additional Programs; Low Income Pool; Low Income Pool Milestones; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Measurement of Quality of Care and Access to Care Improvement.

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. On December 15, 2011, CMS agreed to extend the demonstration through June 30, 2014.

The December 2011 renewal included several important improvements to the demonstration, such as; enhanced managed care requirements to ensure increased stability among managed care plans, minimize plan turnover, and provide for an improved transition and continuity of care when enrollees change plans and to ensure adequate choice of providers. The renewal also included a Medical Loss Ratio (MLR) requirement of 85 percent for Medicaid operations. Finally,

the renewal included the continuation of the Low Income Pool (LIP) of $1 billion (total computable) annually to assist safety net providers in providing health care services to Medicaid, underinsured and uninsured populations.

On June 14, 2013, CMS approved an amendment to the demonstration which retains all of the improvements noted above, but allows 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 changes the name of the demonstration to the Florida Managed Medical Assistance (MMA) program. Beginning no earlier than January 1, 2014, the MMA program implementation will begin. The Medicaid Reform demonstration will remain in effect in the five Medicaid Reform counties until the MMA program is implemented.

Under the amended demonstration, most Medicaid eligibles are required to enroll in a managed care plan (either a capitated managed care plan or a FFS PSN as a condition for receiving Medicaid. Participation is mandatory for TANF related populations and the aged and disabled with some exceptions. The demonstration continues to allow 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 that will be replaced by the plan's Healthy Behaviors program upon implementation of the MMA program as described in paragraph 65. Beneficiaries in counties transitioning from Medicaid Reform to MMA will continue to have access to their accrued credits under EBAP for one year.

The amended terms and conditions include improvements such as:

- A phased implementation to ensure readiness including a readiness assessment for each region and a requirement for CMS approval of the state's implementation plan which will include identified risks, mitigation strategies, and fail safes, stakeholder engagement and rapid cycle improvement strategies;
- Strengthened auto-enrollment criteria to ensure consideration of network capacity, access, continuity of care, and preservation of existing patient-provider relationships when enrolling all beneficiaries into the MMA program, including special populations;
- STCs tailored to special populations, should the state choose to include specialty plans in the final selection of managed care entities and PSNs;
- Strong consumer protections to ensure beneficiary assistance and continuity of care through the MMA transition. Additional STCs to ensure beneficiary choice, including a comprehensive outreach plan to educate and communicate with beneficiaries, providers, and stakeholders and annual Health Plan Report Cards for consumers, which will allow beneficiaries to be more informed on health plan performance and assist beneficiaries in making informed decisions related to plan selection;
- Enhanced Medical Care Advisory Committee (MCAC) requirements to ensure beneficiary and advocate group participation as well as inclusion of sub-population advisory committees;
- Performance Improvement Projects (PIPs) to be performed by all health plans;
- Clarification and enhancements of the monitoring and evaluation of plans to ensure a rigorous and independent evaluation, and development of rapid cycle, transparent monitoring in order to ensure continuous progress towards quality improvement; and,
- A Comprehensive Quality Strategy (CQS) that will span the entire Florida Medicaid program.

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.

The state has complied with federal non-discrimination statutes including, but are not limited to, the American 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, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

The state has complied with Medicaid law, regulation, and policy including all requirements of the Medicaid Program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the demonstration award letter of which these terms and conditions apply.

3. **Changes in 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, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

Since the implementation of the demonstration, the state has worked closely with Federal CMS's Central and Regional and Central Offices to ensure compliance with any changes in Federal law.

4. Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.

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.

The state is in compliance with Federal law, regulation and policy statements.

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.

The state is in compliance with this term and condition of the waiver.

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.

The state has not made any of the changes specified above to the demonstration since receiving approval from Federal CMS for the amendment to implement the Managed Medical Assistance program on June 14, 2013.

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 16, 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.

The state has not submitted an amendment to the demonstration since receiving approval from the Federal CMS for the amendment to implement the Managed Medical Assistance on June 14, 2013. The MMA program amendment was submitted in compliance with this term and condition.

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 61).

On June 28, 2013, the state provided Federal CMS notice the Enhanced Benefits Account program would be phased out in accordance with this term and condition of the waiver. Based on the draft implementation schedule for the MMA program, the Enhanced Benefits Account program will be phased out, on a staggered basis, as the MMA program is implemented. The following were the key dates provided for phasing out the EBA program:

***July 31, 2013**: First notification to recipients and health plans.*

***January 1, 2014**: Second notification to recipients and health plans.*

***June 30, 2014**: Last day for recipients to earn credits under the EBA program.*

***July 1, 2014 – June 30, 2015**: Recipients who have accrued credits will be able to access their credits for up to one year.*

***July 1, 2015**: Termination of the EBA program.*

As part of the information provided Federal CMS on June 28, 2013, the state included (1) a copy of the letter to be sent to recipients notifying them of the program termination along with the last date to earn credits and the last date to spend credits earned; and (2) a copy of the letter to be sent to health plans notifying them of the program termination along with the last date for recipients to earn credits and the last date for recipients to spend credits earned. The letters to recipients and health plans were sent July 31, 2013.

The state will submit an updated phase-out plan to Federal CMS for approval no later than 6 months prior to the termination of the Enhanced Benefit Account program in accordance with this term and condition of the waiver.

9. Extension of the Demonstration

a) States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 10.

b) As part of the demonstration extension request, the state must provide documentation of compliance with the transparency requirements in 42 CFR § 431.412 and the public notice requirements outlined in paragraph 16, as well as include the following supporting documentation:

   i. Historical Narrative Summary of the Demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The state must provide summaries of External Quality Review Organization (EQRO) reports, health plan state quality assurance monitoring, and any other documentation of the quality of care provided or corrective action taken under the demonstration.

v. Financial Data: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If Title XXI funding is used in the demonstration, a CHIP allotment neutrality worksheet must be included.

vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Documentation of Public Notice 42 CFR § 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

The state is submitting the waiver extension request for the period July 1, 2014 through June 30, 2017 in compliance with this term and condition of the waiver.

10. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30- day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation

state plan amendment. Once the 30- day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

The state will comply with this term and condition if the state decides to phase out the waiver.

11. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

a) Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

b) Expiration Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

c) Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input

on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d) Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

The state will comply with this term and condition regarding expiring demonstration authority.

12. 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.

The state acknowledges CMS's right to terminate or suspend the demonstration in whole or in part at any time before the date of expiration as specified in this term and condition of the waiver.

13. Finding of Non-Compliance. The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

The state has not been informed or notified of any finding of non-compliance by CMS.

14. 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.

The state acknowledges this term and condition of the waiver which specifies that CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX.

15. 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.

The state has and continues to ensure the availability of adequate resources for implementation and monitoring of the demonstration as specified in this term and condition of the waiver.

16. 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.

The state has complied with this term and condition of the waiver regarding public notice and consultation with interested parties when any program changes to the demonstration are proposed by the state.

17. 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 maintain:

a) Policies to ensure an increased stability among capitated managed care plans and FFS PSNs and minimize plan turnover. This could include a limit on the number of participating plans in the five Medicaid Reform demonstration counties and, when implemented, in the MMA program. 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 MMA program demonstration amendment.

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 MMA program demonstration amendment.

c) A requirement that each capitated managed care plan and capitated PSN maintain an annual Medical Loss Ratio (MLR) of 85 percent for Medicaid operations in the demonstration counties. These entities must provide documentation to the state and CMS at least annually 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. MLR requirements are to be reported by the capitated plans 7 months after the quarter ends to allow for the claims run-out period. 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.

e) Policies to ensure adequate choice of providers 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.

f) Policies that result in a network of appropriate dental providers sufficient to provide adequate access to all covered dental services, in accordance with 42 CFR 428.206.

The state has complied with this term and condition of the waiver regarding managed care requirements published in 42 CFR 438 including provisions noted in 17d through 17f; and the capitation rates are developed and have been certified as actuarially sound in accordance with 42 CFR 438.6. In addition, the state submitted the required managed care policies specified in 17a and 17b on September 12, 2013. The state has demonstrated compliance with 17c with the submission of the MLR reporting schedule and the plan's first MLR quarter reports on May 15, 2013 (covering the period July 1, 2012 - September 30, 2012; the second MLR quarter reports on August 13, 2013 (covering period October 1, 2012 - December 31, 2013); and the third MLR quarter reports on November 9, 2013 (covering period January 1, 2013 – March 31, 2013).

18. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 90, associated with the quarter in

which the forum was held. The state must also include the summary in its annual report as required in paragraph 91.

The state has complied with this term and condition by publishing the Post Award Forum public notice in the Florida Administrative Register 30 days prior to the public meeting on September 13, 2013 (see Attachment A.4 of this document). The Post Award Forum was held on October 15, 2013 with the Medical Care Advisory Committee. A summary of the comments received during the Post Award Form held on October 15, 2013 will be reported in the second quarter report to be submitted by February 28, 2014 and the annual report to be submitted by October 28, 2014. A summary of the comments received during the Post Award Form were included in this document under Section III.H. The state will hold an annual Post Award Forum to afford the public with an opportunity to provide meaningful comment on the progress of the demonstration.

IV. Eligibility for Medicaid Reform and the Managed Medical Assistance Program

19. Consistency with State Plan Eligibility Criteria. There is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. 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. See section XII.

The state has complied with this term and condition and assures Federal CMS that the eligibility criteria under the demonstration are consistent with the criteria in the State Plan.

20. Participation in Medicaid Reform. The following eligibility requirements remain in effect for Reform counties until such time that the MMA program is established in the Reform counties. Note: the MMA program must not be implemented earlier than January 1, 2014. 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 capitated managed care plan or FFS PSN as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a demonstration capitated managed care plan or FFS 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 94)
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

Mandatory State Plan Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Demonstration Population (See STC 94)
Blind/Disabled Children	Children eligible under SSI	Population 1
TANF Pregnant women	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.)	Population 7
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

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 not residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID);

   iii. Individuals receiving hospice services;

   iv. Pregnant women with incomes above the 1931 poverty level;

   v. Medicare-Medicaid eligible individuals;

   vi. Children under age 1 with family income 186% - 200% of the FPL under Title XXI; and,

   vii. Children under age 18 eligible for adoption assistance.

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 (age 21 and over);

   iv. Family planning waiver eligibles;

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

   vi. Individuals in an intermediate care facility for individuals with intellectual disabilities

(ICF-IID).

The state has complied with this term and condition and assures Federal CMS that participation in the Mediciad reform program is consistent with the specified requirements.

21. Participation in the MMA program. The following describes the MMA program participation. Note: the MMA program must not be implemented earlier than January 1, 2014. MMA program participants are individuals eligible under the approved state plan, who reside in the MMA program regions and who are described below as "mandatory participants" or as "voluntary participants". Mandatory participants are required to enroll in a capitated managed care plan or FFS PSN as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a demonstration capitated managed care plan or FFS PSN to receive Medicaid benefits.

a) Mandatory Participants – Individuals who reside in one of the eleven regions where the MMA program has been implemented, who belong to the categories of Medicaid eligibles listed in the following table, and who are not listed as excluded from mandatory participation are required to be MMA program participants.

Mandatory State Plan Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Demonstration Population (See STC 94)
Infants under age 1	Up to 150% of the Federal Poverty Level(FPL)	Population 7
Children under age 1	With family income 186% - 200% of the FPL under Title XXI	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
Foster Care	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL - Title IV-E)	Population 7
TANF Pregnant women	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.	Population 7
Pregnant women with incomes above the 1931 poverty level	Income greater than 1931 income level and not exceeding 150% of FPL.	Population 7

Mandatory State Plan Groups	Federal Poverty Level (FPL) and/or Other Qualifying Criteria	Demonstration Population (See STC 94)
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 200% of the FPL	Population 7
Adoption assistance under age 18	Who receive an adoption subsidy	Population 7
Pregnant women with incomes above the 1931 poverty level	Income greater than 150% of Federal Poverty Level (FPL) and not exceeding 185% of FPL	Population 7
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.	Population 1

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

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

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

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

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

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

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;

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

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

The state is in compliance this term and condition and assures Federal CMS that participation in the MMA program will be consistent with the specified requirements.

V. Enrollment

This section describes enrollment provisions that are applicable to Medicaid eligible individuals living in Florida counties in which either Medicaid Reform or the MMA program demonstration has been implemented.

22. New 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 capitated managed care plan or a FFS PSN in the Reform Counties or the MMA program when implemented. 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. Once the plan selection is registered and takes effect, the plan must communicate to the enrollee, in accordance with 42 CFR 438.10, the benefits covered under the plan, including dental benefits, and how to access those benefits.

The state is in compliance with this term and condition and assures Federal CMS new enrollees: a) receive information about their managed care plan choices in their area, b) are provided an opportunity to meet or speak with a choice counselor to obtain information on making a choice of plans; c) given 30 days to select a plan from their date of eligibility determination; d) if the recipient does not select a plan within the 30 day choice period, the recipient is auto-assigned to a capitated plan or FFS PSN under the reform program and will be auto-assigned to a MMA plan under the MMA program; e) upon registering the plan selection, the plans must communicate to the enrollee in accordance with 42 CFR 438.10.

23. Auto-Enrollment Criteria. Each enrollee must be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the choice counselor must 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 must 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 include but are not limited to:

a) A managed care plan has sufficient provider network capacity, including dental 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 FFS 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.

The state has complied with this term and condition regarding auto-assignment of recipients to plans in their area. The state assures Federal CMS that: a) each recipient is given 30 days to select a plan after being determined eligible for Medicaid; b) within the 30-day period, the choice counselor provides information to the recipient to encourage an active plan selection; c) recipients who fail to choose within this timeframe are auto-assigned to a plan; d) at a minimum, the state uses the criteria listed below when assigning recipients to a plan; e) when more than one plan meets the assignment criteria, the state makes recipient assignments consecutively by family unit. The auto-assignment criteria include but are not limited to:

a) A managed care plan has sufficient provider network capacity, including dental 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 FFS 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.

24. Auto Enrollment for Special Populations. 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 must determine whether the SSI beneficiary has an ongoing relationship with a provider or managed care plan; and if so, the state must assign the SSI recipient to that managed care plan whenever feasible. Those SSI recipients who do not have such a provider relationship must be assigned to a managed care plan using the assignment criteria previously outlined.

In addition, the state must use the following parameters when assigning a recipient to a plan.

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

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

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

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

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

The state has complied with this term and condition of the waiver regarding auto enrollment for special populations. The state assures Federal CMS that: a) for recipients who are also a recipient of Supplemental Security Income, prior to assigning the Supplemental Security Income recipient to a plan, the state determines whether the Supplemental Security Income recipient has an ongoing relationship with a provider or managed care plan; and if so, the state assigns the Supplemental Security Income recipient to that plan whenever feasible; b) for those Supplemental Security Income recipients who do not have such a provider relationship the state assigns them to a plan using the assignment criteria previously outlined. In addition, the state will use the following parameters when assigning a recipient to a MMA plan.

a) To promote alignment between Medicaid and Medicare, each recipient who is enrolled with a Medicare Advantage Organization, will first be assigned to any MMA 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 should be assigned as in paragraphs (a)-(d) above.
b) If an applicable specialty plan is available, the recipient should be assigned to the specialty plan.
c) If, in the first year of the first MMA contract term only, a recipient was previously enrolled in a plan that is still available in the region, the recipient should be assigned to that plan.
d) Newborns of eligible mothers enrolled in a plan at the time of the child's birth will be automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 90 days after the child's birth.
e) Foster care children will be assigned/re-assigned to the same plan/PCP to which the child was most recently assigned in the last 12 months, if applicable.

25. Lock-In/Disenrollment. Once a mandatory enrollee has selected or been assigned a Medicaid Reform plan or MMA 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 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 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 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 plan at any time.

The choice counselor or state 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.

The state has complied with this term and condition of the waiver regarding lock-in/disenrollment requirements. Upon enrollment in a plan, recipients are given 90 days to disenroll from their plan without cause and to disenroll with cause at anytime. The state assures Federal CMS the lock-in/disenrollment requirements will be followed under the MMA program when implemented. The state's choice counselor maintains a record of recipient plan changes/disenrollment reasons for all recipients who request a change. The state's choice counselor is responsible for processing all enrollments and disenrollments under the Medicaid Reform program in compliance with federal regulations. The state's choice counselor will continue to be responsible for processing all enrollments and disenrollments under the MMA program in compliance with federal regulations.

26. 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 demonstration enrollees in the same capitated managed care plan or FFS PSN they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended.

The state has complied with this term and condition regarding re-enrollment and assures Federal CMS in instance of temporary loss of Medicaid eligibility, recipients are re-enrolled in the same plan they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended.

VI. Benefit Packages and Plan in Medicaid Reform and MMA Program

27. Customized Benefit Packages. Capitated managed care plans will have the flexibility to provide customized benefit packages for demonstration enrollees as long as the benefit package meets certain minimum standards described in this STC, and actuarial benefit equivalency requirements and benefit sufficiency requirements described in STCs 28-32. PSNs operating under FFS 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 contracted with the state shall not have service limits more restrictive than authorized in the state plan for children under the age of 21, pregnant women, and emergency services. The state may also capitate all state plan services for demonstration enrollees.

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

The state has complied with this term and condition and assures Federal CMS the reform plan customized benefit packages meet the standards of actuarial benefit equivalent requirements and benefit sufficiency requirements specified in term and condition #28-32 of the waiver.

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

28. 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.

The state has complied with this term and condition of the waiver. The state has and will continue to prior approve all plan customized benefit packages and ensure they meet actuarial benefit equivalent requirements and benefit sufficiency requirements specified in term and condition #28-32 of the waiver.

29. **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 or has been awarded an MMA 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.

The state has and will comply with this term and condition to utilize plan evaluation tool to determine if a plan meets the state's requirements.

30. **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 managed care plans are equal (using a common benchmark reimbursement structure) to the level of the historic FFS plan for the target population and its historic levels of utilization. The 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.

The state has and will continue to comply with this term and condition regarding the plan evaluation tool and actuarial equivalency.

31. **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.

The state has complied with this term and condition regarding the plan evaluation tool and sufficiency testing of benefits.

32. 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 demonstration 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.

The state has and will continue to comply with this term and condition to review and update the plan evaluation tool for assessing a plan's benefit structure to ensure actuarial equivalence and that services are sufficient to meet the needs of enrollees in the demonstration area or region.

VII. Cost Sharing

33. Premiums and Co-Payments. The state must pre-approve all cost sharing allowed by Reform and MMA plans. Cost-sharing must be consistent with the state plan except that managed care plans may elect to assess cost sharing that is less than what is allowed under the state plan.

The state has and will continue to comply with this term and condition regarding prior approval of all cost sharing allowed by the Medicaid reform plans and the MMA plans. The state assures Federal CMS that the plan cost sharing is consistent with the State Plan except that managed care plan may elect to assess cost sharing that is less than what is allowed under the state plan. The cost sharing provisions under the MMA program are outlined in Section II.F of this document.

VIII. Florida Managed Medicaid Assistance (MMA) Program Implementation.

34. Reform Implementation. Counties where Reform was implemented in 2006 and 2007 are known as Reform Counties (Baker, Broward, Clay, Duval, and Nassau). No earlier than January 1, **2014**, these counties will become MMA program counties when the MMA program is implemented in their respective region. Transition from Medicaid Reform counties to the MMA regions will follow implementation requirements as outlined in STCs 35 and 36

The state assures Federal CMS the state will not implement the MMA program prior to January 1, 2014 in the counties specified in this term and condition or in any other region of the state. The state assures Federal CMS it has and will continue to follow the implementation requirements specified in term and conditions 35 and 36 of the waiver.

35. MMA Program Implementation Requirements. No earlier than January 1, 2014, the state may implement the MMA program in a region if it meets the following implementation requirements for that region (subject to CMS review and approval).

Implementation Schedule: The state must submit to CMS a schedule indicating its planned

start date for mandatory enrollment in the MMA program in each region of the state. The state may not begin mandatory enrollment in any region until CMS has approved the implementation plan. After CMS' approval of the implementation plan, the state may stagger mandatory enrollment over period beginning no earlier than January 1, 2014. The state will submit an implementation schedule to CMS by October 31, 2013, that specifies the regions to be transitioned in that timeframe with a staggered implementation approach. The state may revise the implementation schedule as needed, and must promptly notify CMS of any changes. The approved implementation plan will become a future attachment to these STCs.

a) The plan must include:

   i. Identification of triggers that would prevent the state from proceeding with the next regional area for implementation;
   ii. Identification of risks with the implementation;
   iii. A mitigation strategy for the identified risks;
   iv. A fail-safe or back-up plan in the event that the mitigation strategy fails;
   v. Identification of circumstances that would stop the state proceeding with the implementation of the next region;
   vi. The role of stakeholder feedback in determining further implementation of the next region; and
   vii. A detailed description of the rapid cycle improvement process and electronic tracking system.

The state is required to submit an amendment no later than October 31, 2013 to Florida's Section 1915(b) Medicaid Managed Care Waiver, control # FL-01.R08, to reflect the phase out of that waiver.

b) Transition plan. The state must conduct an assessment of the plan transition needs for each region and will explain its policies to promote beneficiary continuity and continuation of care, particularly for beneficiaries who will no longer have access to his or her physician and beneficiaries who are enrolled in a managed care plan for their managed long term services and supports.

c) Notice information. The state must provide notice of the change in program authority and open enrollment to individuals in each region in simple and understandable terms and in a manner that is accessible to persons who are limited English proficient and individuals living with disabilities.

d) Readiness review. The state must assess plan readiness in each region in accordance with the requirements of 42 CFR 438. Readiness reviews will include, but are not limited to, 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 will also notify CMS of its intent to conduct a readiness review 30 days in advance of the review and provide CMS the opportunity to observe the readiness review. The state will provide CMS a copy of their readiness review feedback/corrective action plan letter and approval letters for each readiness review.

e) Solvency assessment. In accordance with STC 17, Managed Care Requirements, the state must evaluate the prior business operations of all health plans that apply to operate in the region, and confirm that they meet solvency standards. The state's managed care contract must include penalties for plans that do not complete the contract term.

f) Compliance with Managed Care requirements. The state must assure that all managed care plans in the region comply with all of the managed care requirements described in paragraph 17 of these special terms and conditions and EPSDT requirements described in paragraph 27 of these STCs.

g) Prior to implementation in each region, the state must submit a report to CMS on its compliance with subparagraphs (b) through (f) above, along with the most recent version of the implementation schedule mentioned in (a). The state may not initiate mandatory MMA program enrollment in a region unless CMS has received this report at least 30 days in advance of the implementation date for each region(s).

The state has and will continue to comply with this term and condition regarding implementation of the MMA program. In compliance with STC 35a, the state submitted the implementation plan and schedule on October 30, 2013 and the phase out amendment to Florida's 1915(b) Managed Care Waiver control # FL-01.R08 on October 31, 2013.

The implementation plan addressed the following requirements: (i) Identification of triggers that would prevent the state from proceeding with the next regional area for implementation; (ii) Identification of risks with the implementation; (iii) A mitigation strategy for the identified risks; (iv) A fail-safe or back-up plan in the event that the mitigation strategy fails; (v) Identification of circumstances that would stop the state proceeding with the implementation of the next region; (vi) The role of stakeholder feedback in determining further implementation of the next region; and (vii) A detailed description of the rapid cycle improvement process and electronic tracking system.

The state assures Federal CMS it will comply with paragraphs (b) through (g) of this term and condition regarding the implementation of the MMA program including (b) Transition Plan: the state will conduct an assessment of the plan transition needs for each region and will explain its policies to promote beneficiary continuity and continuation of care, particularly for beneficiaries who will no longer have access to his or her physician and beneficiaries who are enrolled in a managed care plan for their managed long term services and supports; (c) Notice information. The state will provide notice of the change in program authority and open enrollment to individuals in each region in simple and understandable terms and in a manner that is accessible to persons who are limited English proficient and individuals living with disabilities; (d) Readiness review. The state will assess plan readiness in each region in accordance with the requirements of 42 CFR 438. Readiness reviews will include, but are not limited to, 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 will also notify Federal CMS of its intent to conduct a readiness review 30 days in advance of the review and provide Federal CMS the opportunity to observe the readiness review. The state will provide Federal CMS a copy of the readiness review feedback/corrective action plan letter and approval letters for each readiness review; (d) Solvency assessment. In accordance with term and condition 17, Managed Care Requirements, the state will evaluate the prior business operations of all MMA plans that apply to operate in the region, and confirm that they meet solvency standards. The state's managed care contract include penalties for plans that do not complete the contract term; and (g) Compliance with Managed Care requirements. The state assures that all MMA plans in each region will comply with all of the managed care requirements described in term and condition #17 and EPSDT requirements described in term and condition 27 of the waiver.

36. MMA **Program Regions.** The MMA program shall be implemented over a period beginning no earlier than January 1, 2014 and no later than October 1, 2014, as described in paragraph 35. The MMA program implementation regions are defined as follows:

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

The state assures Federal CMS that the MMA program will be implemented no earlier than January 1, 2014 and no later than October 1, 2014, as describe in term and condition 35. The state assures Federal CMS that the program regions are those listed in this term and condition.

IX. Delivery Systems

37. Health Plans. Health plans authorized under this demonstration must be authorized by state statute and must adhere to 42 CFR 438. Contracts with these entities may be risk or non-risk contract types. 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 final contracts developed to implement selective contracting by the state with any managed care organization, provider group, Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) shall be subject to CMS Regional Office approval prior to implementation.

a) Capitated Managed Care Organization – An entity (such as Health Maintenance Organization, Accountable Care Organization, capitated Provider Service Network, or Exclusive Provider Organization) that meets the definition of managed care organization (MCO) as described in 42 CFR 438.2, and which must conform to all of the requirements in 42 CFR 438 that apply to MCOs.

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 FFS or capitated basis as specified in state statute. Capitated PSNs are categorized as MCOs, and must meet the requirements as described in 42 CFR 438.

c) Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP)- Entities that meet the definition or PIHP or PAHP as described in 42 CFR 438.2 and which must conform to all requirements in 42.CFR 438 that apply to PIHPs and PAHPs.

The state assures Federal CMS that the MMA plan contracts authorized under this demonstration are authorized by state statute and will adhere to 42 CFR 438. The contracts with these entities may be risk or non-risk contract types and capitation rates will be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification will identify historical utilization of state plan services used in the rate development process.

The state shall submit the final contracts developed under the MMA program to Federal CMS Regional Office for approval prior to implementation.

38. Number of Plans per Region. The state will procure a specified number of plans per region for the MMA program. A minimum and maximum number of plans are specified by region, with a minimum of two plans choices in each of the 11 regions. Of the total contracts awarded per region, at least one award shall be a PSN if any PSNs submit a responsive bid. Issuance and award of the procurements will provide for a choice of plans, as well as market stability.

Should the state not be able contract with at least two plans in a region that is not rural, the state will issue another procurement to obtain a second plan and meet the federal requirements in 438.52. Until two plans are available in the impacted region, beneficiaries may voluntarily choose to enroll in the available managed care plan or to access services through a FFS delivery system.

In addition to regional plans, the state will also seek to contract with specialty plans, as discussed in STC 40. Participation of specialty plans will be subject to competitive procurement requirements but will not be considered in assessing regional plan availability. However, the state may not enter into contracts with specialty plans to the extent that the target populations include more than 10 percent of the enrollees of any one region.

Once the state has selected the managed care plans for the MMA program through its competitive bidding process, the state will submit a report to CMS no later than October 31, 2013, that will include:

a) The name of the managed care plans selected for each region;
b) For the selected plans, please identify those plans that also provide long term services and supports under the 1915(b)(c) waivers;
c) The names of managed care plans that will not be continuing by region; and,
d) The number of enrolled beneficiaries in each plan that will not be continuing.

The state assures Federal CMS the state will procure the specified number of plans per region for the MMA program as outlined in state law and this term and condition. The state submitted the plan selection report to Federal CMS on October 31, 2013, as required by this term and condition.

39. 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 FFS delivery systems as necessary to meet the choice requirements as under 42 CFR 438.52.

a) Beneficiaries also have a choice of at least two regional health plans in each region. While beneficiaries are encouraged to select the same MMA plan as their Medicare Advantage or LTC Plan, it is not a requirement.

b) Should a beneficiary choose an MMA health plan that is different from their Medicare Advantage or LTC plan, the two entities must coordinate the beneficiaries care to ensure that all needs are met.

The state assures Federal CMS all recipients have a choice of at least two regional MMA plans in each region. The choice of at least two providers includes the Enhanced Benefit Account program population enrolled in the Medicaid Reform program. The state will provide recipients access to the FFS delivery system if a recipient has less than two plans to choose from in accordance with 42 CFR 438.52, Freedom of Choice.

The state assures Federal CMS that if a recipient chooses an MMA plan that is different than their Medicare Advantage or Long-term Care managed care plan, the two entities will coordinate the recipient's care to ensure that all needs are met.

40. Specialty Plans. The contracted plans in the MMA program regions will be encouraged to develop and offer specialty plans to serve individuals with specific conditions or select eligibility groups.

A specialty plan is defined as a plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs individuals and that has been approved by the state as a specialty plan. Specialty plans are designed for a specific population and currently include 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). Participation of specialty plans will be subject to competitive procurement requirements and the aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the enrollees of that region.

The state will identify specialty plans as part of the procurement process and may approve specialty plans on a case-by-case basis using criteria that include appropriateness of the target population and the existence of clinical programs or special expertise and/or providers to serve that target population. The state will not approve plans that discriminate against sicker members of a target population.

The state may also contract with Medicare Advantage Organizations, to serve Medicare-Medicaid enrollees, authorized by the Centers for Medicare & Medicaid Services.

In addition to meeting general financial reserve requirements and network sufficiency requirements, the state will develop enhanced standards for specialty plans that may include but are not limited to:

a) Appropriate integrated provider network of primary care physicians and specialists who are trained to provide services for a particular condition or population. The network should be an integrated network of primary care physicians (e.g., nephrologists for kidney disease; cardiologists for cardiac disease; infectious disease specialists and immunologists for HIV/AIDS).
b) Network with sufficient capacity of board-certified specialists in the care and management of the disease for plans that seek to focus services for enrollees with a particular disease state. In addition, it is recognized that individuals have multiple diagnoses, and, therefore, the plan should have sufficient capacity of additional specialists to manage the different diagnoses.
c) Defined network of facilities that are used for inpatient care, including the use of accredited tertiary hospitals and hospitals that have been designated for specific conditions (e.g., end stage renal disease centers, comprehensive hemophilia centers).
d) Availability of specialty pharmacies, where appropriate.
e) Availability of a range of community-based care options as alternatives to hospitalization and institutionalization.
f) Clearly defined coordination of care component that links and shares information between and among the primary care provider, the specialists, and the patient to appropriately manage co-morbidities.
g) Use of evidence-based clinical guidelines in the management of the disorder.
h) Development of a care plan and involvement of the patient in the development and management of the care plan, as appropriate.
i) Development and implementation of a disease management program specific to the specialty population(s) or disease state(s), including a specialized process for transition of enrollees from disease management services outside of the plan to the plan's disease management program

The state will comply with this term and condition regarding specialty plan. This includes but is not limited to complying with: (a) the specified definition of a specialty plan, (b) identification of specialty plans as part of the procurement process and approval of specialty plans on a case-by-case basis as specified, (c) not approve plans that discriminate against sicker members of a target population, (d) if available, contract with Medicare Advantage Organizations, and (e) establish enhanced standards for specialty plans as specified in this term and condition.

The Agency has contracted with the specialty plans specified in the plans selection report provided to Federal CMS on October 31, 2013.

41. Incentives are included for plans that exceed Agency defined quality measures. Plans that exceed such measures during a reporting period may retain an additional 1 percent of revenue.

The state will comply with this term and condition regarding incentives for plans that exceed Agency defined quality measures.

42. Requirements for Special Populations.

a) HIV Specialty Plans

i. The state will mandatorily enroll Medicaid beneficiaries identified with a diagnosis of HIV or AIDS to a specialty plan, where available, and when the beneficiary does not select an MMA plan during the 30 day choice period. These beneficiaries may be identified with a combination of diagnosis codes on current claims; HIV or AIDS prescription medications; and laboratory tests and results.

ii. The state will notify beneficiaries identified with a diagnosis of HIV or AIDS in writing that the beneficiary must select an MMA plan during the 30 day choice period or the beneficiary will be assigned to a specialty plan available in his or her region. The notification will provide the beneficiary with information regarding the benefits of enrolling in a specialty plan and the 90 day period to make another plan selection without cause.

iii. When making assignments to an HIV/AIDS specialty plan, the state will consider the beneficiary's PCP and/or current prescriber of HIV or AIDS medications.

iv. When making assignments to HIV/AIDS specialty plans and the beneficiary's PCP or current prescriber of HIV or AIDS medications is not known or is not an enrolled provider with a specialty plan, the state will assign the beneficiary to a specialty plan available on a rotating basis.

v. When making assignments to HIV/AIDS specialty plans of beneficiaries who are determined to have co-morbid conditions, the state may assign the beneficiary to the most appropriate specialty plan available in the beneficiary's region.

b) Children's Specialty Plans

i. The State may elect to contract with Children's Specialty Plans to serve Foster Care Children. These plans will have special requirements for immediate assessment, care coordination, and treatment of Foster Care Children. The Children's Specialty Plans are required to furnish EPSDT for Foster Care Children and follow the State's medication formulary for first year of the MMA Program.

ii. During the plan selection period, the Foster Care child's legal guardian may choose to enroll in an MMA health plan or the Children's Specialty Plans that are available in the child's region.

iii. Should a Foster Care child's legal guardian fail to make an affirmative selection of an MMA health plan, the state may enroll the foster care child into the Children's Specialty Plan available in the region.

The state assures Federal CMS it will comply with this term and condition regarding special populations specifically related to HIV/AIDS Specialty Plans and Children's Specialty Plans.

X. Consumer Protections

43. Medical Care Advisory Committee. In accordance with 42 C.F.R. §431.12, the state must maintain its Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services. The state must ensure that the MCAC is comprised of the representatives set forth in 42 C.F.R. §431.12(d). The state must ensure that the MCAC

includes representation of at least four beneficiaries at all times and report to CMS any vacant beneficiary slots that are not filled within 90 days of the date of this amendment or within 90 days of becoming vacant. The state may submit justification to CMS for an unfilled beneficiary slot after 90 days and CMS may grant an exception to this requirement at CMS' discretion. The MCAC must present recommendations and suggestions to the state on the state's comprehensive quality strategy, as described in STC 118.

Subpopulation Advisory Committees. In addition to the MCAC, the state must convene smaller advisory committees that meet on a regular basis (at least quarterly) to focus on subpopulations, including, but not limited to: beneficiaries receiving managed long-term services and supports; beneficiaries with HIV/AIDS; children, including safeguards and performance measures related to foster children and the provision of dental care to all children; and beneficiaries receiving behavioral health/substance use disorder services.

Each advisory committee must include representation from relevant advocacy organizations, as well as beneficiaries. Each advisory committee must present recommendations and suggestions to the state on the state's comprehensive strategy, as set forth in STC 118. In addition, each advisory committee must provide input to the state on the consumer report cards, set forth in STC 115.

The state assures Federal CMS it is in compliance with this term and condition regarding the Medical Care Advisory Committee.

The state submitted the required notice to Federal CMS regarding compliance with representation of at least four recipients on the committee on September 12, 2013. The state will notify Federal CMS within 90 days of any recipient slots that become vacant. The state is working with the Medical Care Advisory Committee to establish the subpopulation groups as required by this term and condition.

The state met with the Medical Care Advisory Committee on September 17, 2013 to obtain recommendations regarding the state's draft Comprehensive Quality Strategy in compliance with term and condition 118 of the waiver. The draft Comprehensive Quality Strategy document was provided to the committee prior to the committee meeting. The state also posted the draft Comprehensive Quality Strategy document on the Agency's website for public review and comment from September 1, 2013 until September 30, 2013. The state considered all comments received from the committee in the final draft document submitted to Federal CMS.

The state will meet with the Medical Care Advisory Committee to obtain recommendations regarding the MMA plan report card described in term and condition 115 of the waiver.

44. Appointment Assistance. The state must provide, or ensure the provision of, necessary assistance with transportation and with scheduling appointments for medical, dental, vision, hearing, and mental health.

The state assures the reform plans and MMA plans provide necessary assistance with transportation and with scheduling appointments for medical, dental, vision, hearing and mental health services.

45. **Attempts To Gain an Accurate Beneficiary Address.** The state shall implement the CMS approved process for return mail tracking. The state will use information gained from return mail to make additional outreach attempts through other methods (phone, email, etc.) or complete other beneficiary address analysis from previous claims to strengthen efforts to obtain a valid address.

The state assures Federal CMS it has implemented an approved process for return mail tracking as specified in this term and condition.

46. **Verification of Beneficiary's Health plan Enrollment.** The state shall utilize and publicize for health plan network and non-network providers the following eligibility verification processes for beneficiaries' eligibility to be verified so that beneficiaries will not be turned away for services if the beneficiary does not have a card or presents the incorrect card. Providers with a valid Medicaid provider number may use any of the following options to determine enrollee eligibility:
    a) Utilize the Medicaid Eligibility Verification System (MEVS): eligibility transactions may be submitted using computer software supplied by the vendor, via a point of sale device similar to those used for credit card transactions, over the telephone using a voice response system, or other possibilities depending on what the MEVS vendor offers;
    b) Perform single transactions (individual verifications) or batch transactions via a secure area on the Medicaid fiscal agent's web portal;
    c) Utilize the Automated Voice Response System (AVRS): providers enter information via a touchtone telephone and it generates a report with all of the eligibility information for a particular recipient, which can be faxed to the provider's fax machine;
    d) Submit eligibility transactions via the Electronic Data Interchange (EDI);
    e) Contact the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799; or,
    f) Contact their local Medicaid area office for assistance.

The state is complying with this term and condition regarding verification of recipient health plan enrollment.

47. **Call Center Availability**. The state must keep the existing (non-continuing) health plan call centers open for the first month of implementation to direct callers to either the state, the enrollment broker, or their new health plan.

The state assures Federal CMS it will comply with this term and condition regarding call center availability of existing (non-continuing) plans.

48. **Sample Notification Letters**. The state must send sample beneficiary notification letters to the existing Medicaid providers, either through direct mailing, posted on the MMA program

website, or other widely distributed method, so providers are informed of what is being told to the beneficiaries regarding their transition to the MMA program.

The state assures Federal CMS it will send sample recipient notification letters to the existing Medicaid providers, either through direct mailing, posting on the MMA program website, or other widely distributed methods, to ensure providers are informed of what the state is telling recipients regarding their transition to the MMA program.

49. Educational Tour and Outreach for Beneficiaries, Providers, and Stakeholders.

a) The state must develop a comprehensive outreach plan to include strategies for communicating with beneficiaries throughout the implementation process. The outreach plan should identify ways in which the state will work collaboratively with beneficiaries, and stakeholders, including the enrollment broker, choice counseling entities, and any other group providing enrollment support for beneficiaries or providers through written notice distribution, outgoing phone calls or other method. The state must initiate beneficiary outreach at least 90 days prior to the implementation of the MMA program in a region and continue through the first 90 days after the implementation of the MMA program.

b) The state must develop a comprehensive outreach plan to include strategies for communicating with providers throughout the implementation process. The outreach plan should identify ways in which the state will work collaboratively with providers and health plans to address providers' questions and concerns regarding implementation. Communication and technical assistance to providers should include webinars, trainings on various topics, Q &A documents, and telephone assistance as applicable.

The state has and will continue to comply with this term and condition regarding education tour and outreach for recipients, providers and stakeholders. The state included a description of the comprehensive outreach plan as part of the implementation plan submitted October 30, 2013. The state also included the draft outreach schedule with this submission. The state will initiate recipient outreach at least 90 days prior to the implementation of the MMA program in a region and continue through the first 90 days after implementation in a region. Communication and technical assistance to providers will include webinars, training on various topics, frequently asked questions document and telephone assistance.

50. Continuation of Care During the Transition Period. Beneficiaries whose health plans will not continue in their region under the MMA program may continue to receive services from their treating provider for up to 60 calendar days after their enrollment effective date under their new MMA health plan.

a) Communication regarding the continuation of services will be publicized through the State's outreach and community strategy to beneficiaries, providers, and the general public.

b) Health plans will be required to authorize services and reimburse providers whether the provider is contracted with the health plans or an out of network provider.

c) If the health plan has not contracted with the treating provider, the health plan must notify enrollees before the 90 day disenrollment period has ended, that they will not be able to continue with the treating provider and provide the option to either:

i. Continue services with a network provider; or,
ii. Disenroll for cause.

The state assures Federal CMS recipients, whose existing plans will not continue in their region under the MMA program, may continue to receive services from their treating provider for up to 60 calendar days after their enrollment effective date under their new MMA plan. The state assures Federal CMS compliance with the following requirements: (a) Communication regarding the continuation of services will be publicized through the state's outreach and community strategy to recipients, providers, and the general public; (b) MMA plans will be required to authorize services and reimburse providers whether the provider is contracted with the plan or an out of network provider; and (c) If the MMA plan has not contracted with the treating provider, the plan will be required to notify enrollees before the 90 day disenrollment period has ended, that the recipient will not be able to continue with the treating provider and provide the option to either: (i) continue services with a network provider; or, (ii) disenroll for cause.

51. Operated Call Center Operations. The state must operate a call center(s) independent of the health plans for the duration of the demonstration. This can be achieved either by providing the call center directly or through the enrollment broker or other state contracted entities. Call center operations should be able to help enrollees in making independent decisions about plan choice, and be able to voice complaints about each of the health plans independent of the health plans.

The state assures Federal CMS it will operate a call center(s) independent of the Medicaid reform plans and the MMA plans for the duration of the demonstration. The state choice counselors will be able to help recipients in making independent decisions about their plan choice, and be able to voice complaints about each of the plans independent of the plans.

52. Call Center Response Statistics. During the first 30 days of implementation the state must review all call center response statistics daily to ensure all contracted entities are meeting service level agreements in their contracts. If deficiencies are found, the state and the entity must determine how they will remedy the deficiency as soon as possible. After the first 30 days, if all entities are consistently meeting requirements, the state can lessen the review of call center statistics, but must still review all statistics at least weekly for the first 60 days of implementation. Data and information regarding call center statistics, including beneficiary questions and concerns, must be made available to CMS upon request.

During the first 30 days of implementation, the state assures Federal CMS that it will review all call center response statistics daily to ensure compliance with service level agreements in their contract. If deficiencies are found, the state will work with its choice counselor to determine how the choice counselor will remedy the deficiency as soon as possible. After the first 30 days, if the state's choice counselor is consistently meeting requirements, the state will lessen the review but will continue to review the statistics at lease weekly for the first 60 days of implementation. Call Center statistics will be made available to Federal CMS upon request.

53. Auto-assignment Algorithm Review. The state must review the outcomes of the auto-assignment algorithm, and if a health plan is found to get a larger number of beneficiaries associated with no match to an existing provider relationship due to a more limited network,

that entity will not be able to receive as many auto-assignees until such time as the network has improved.

The state assures Federal CMS it reviews the outcomes of the auto-assignment algorithm and will continue its review when the MMA program is implemented. If a plan is found to receive a greater number of recipients associated with no match to an existing provider relationship due to a more limited network, that plan will not be able to receive as many auto-assignments until such time as the plan's network has improved.

54. Implementation Calls with the Health Plans. The state must develop a schedule of calls with health plans during implementation of MMA program to discuss any issues that arise. The state must submit a copy of the schedule of implementation calls to CMS and allow CMS the opportunity to participate in the state's implementation calls with health plans. The calls should cover all health plans operations and determine plans for correcting any issues as quickly as possible. For the first 60 days in which the region transitions to the MMA program CMS will require weekly reporting of issues encountered and plans for and status of resolution during the Implementation Monitoring conference calls specified in STC 89.

The state assures Federal CMS it will develop a schedule of calls with the plans during implementation of the MMA program to discuss any issues that arise. The state will submit a copy of the schedule of calls with the MMA plans to Federal CMS and will allow Federal CMS the opportunity to participate on the calls. The call will cover all plan operations and determine plans for correcting any issues identified as quickly as possible. For the first 60 days in which the region transitions to the MMA program, the state will submit weekly reports of issues encountered and plans for and status of resolution during the state monitoring conference calls as specified in term and condition 89 of the waiver.

55. State Review of Beneficiary Complaints, Grievances, and Appeals. During the initial implementation of MMA program, the state must review complaint, grievance, and appeal logs for each health plan and data from the state or health plan operated incident management system, to understand what issues beneficiaries and providers are having with each of the health plans. The state will use this information to implement any immediate corrective actions necessary. The state must review these statistics at least weekly for the first 60 days in which the region transitions to the MMA program. The state will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports as specified in STC 90. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

During the initial implementation of the MMA program, the state assures Federal CMS will review complaints, grievances and appeal logs of each plan and data from the state or plan operated incident management system, to understand recipient and provider issues with each of the plans. The state will review the statistics at least weekly for the first 60 days in which the region transitions and will continue to monitor these statistics throughout the demonstration period. The state will report on these statistics in the quarterly reports and the data will be made available to Federal CMS upon request.

XI. Choice Counseling

56. Choice Counseling Defined. The state shall contract for choice counselor services in Reform Counties and the MMA program regions 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.

The state has complied with this term and condition and will continue to after the implementation of the MMA program. The state assures Federal CMS recipients are provided full and complete information about their plan choices. The state assures the choice counseling system promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.

57. 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.

The state assures Federal CMS through the choice counselor it offers an extensive recipient education and rating system so recipients fully understand their choices and so recipients are able to make an informed plan selection. Outcomes important to recipients are measured and will be made available publicly. The state reports on the plan performance in the quarterly report which is submitted 60 days after the end of each quarter and in the annual report which is submitted 120 days after the end of each demonstration year.

58. Choice Counseling Information. The state or the state's administrator provides information on selecting a managed care 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. To ensure the information is as helpful as possible, the state may synthesize information into a coherent rating system.

The state assures Federal CMS the state's choice counselor will provide information on selecting plans including each plan's 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 when available. The state assures Federal CMS plan performance measures, results of consumer satisfaction reviews, and data on access to preventive services will provided under the MMA program when available. The state reports on the Choice Counseling program in the quarterly report which is submitted 60 days after the end of each quarter and in the annual report which is submitted 120 days after the end of each demonstration year.

59. 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, without charge to the enrollee.

The state assures Federal CMS its choice counseling materials are provided variety of ways including the internet, print, telephone, and face-to-face. All written materials are 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. The state's choice counselor also provides oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY, without charge to the recipient.

60. 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 Agency for Health Care Administration's 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.

The state assures compliance with this term and condition regarding contracting with the choice counselor including: (a) recipients are able to contact the choice counselor to obtain additional enrollment information; (b) enrollment information is available via the website or by phone, (c) the state's choice counselor operates a toll-free number, (d) the choice counseling call center operates during business days, with extended hours, and is staffed with professionals qualified to address the needs of the enrollees and potential enrollees, and (e) the state ensures mechanisms are in place to monitor and evaluate choice counseling call center metrics and the individual performance of choice counseling personnel. The state reports on the Choice Counseling program in the quarterly report which is submitted 60 days after the end of each quarter and in the annual report which is submitted 120 days after the end of each demonstration year.

XII. Enhanced Benefits Account Program Under Medicaid Reform and Healthy Behaviors Program Under the MMA Program.

61. Medicaid Reform Enhanced Benefits Account Program Defined. The EBAP provides incentives to capitated managed care plan or FFS PSN 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. EBAP is available only in Medicaid Reform counties prior to implementation of the managed care plan's Healthy

Behaviors programs under the MMA program. The only exception is that recipients who have accrued Enhanced Benefits credits will be able to access the credits for up to one year.

The state has complied with this term and condition regarding the Enhanced Benefit Account program. The state assures federal CMS the program (a) provides incentives to capitated plan or FFS PSN enrollees for participating in state defined activities that promote healthy behaviors, (b) allows recipients, who participates in a state defined activity that promotes healthy behaviors, earns credits that are posted to an individual's account; (c) recipient's earned credits can be used for health care related expenditures as approved under the program and defined in Section 1905 of the SSA; (d) the program is available only in Medicaid reform counties prior to implementation of the plan's Healthy Behaviors programs under the MMA program; and (e) the only exception is that recipients who have accrued Enhanced Benefits credits will be able to access the credits for up to one year after the program is terminated. The state reports on the Enhanced Benefit Account program in the quarterly report which is submitted 60 days after the end of each quarter and in the annual report which is submitted 120 days after the end of each demonstration year.

62. Medicaid Reform EBAP 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.

The state has complied with this term and condition regarding the administration of the Medicaid reform Enhanced Benefit Account program.

63. Medicaid Reform 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".

The state has complied with this term and condition regarding Medicaid reform participants earning Enhanced Benefit Account credits. The state reports on the credits earned by recipients enrolled in the Enhanced Benefit Account program in the quarterly submitted to 60 days after the end of each quarter and annual 120 days after the end of the demonstration year.

64. Expansion Population for the Continuation of the EBAP. In Medicaid in Reform counties, individuals who lose eligibility or transition to MMAP 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. Individuals who lose eligibility for Medicaid 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. Upon implementation of the MMA program, recipients who have accrued credits under Medicaid Reform will be able to access those credits for up to one year. These individuals are identified as demonstration Population A.

The state has complied with this term and condition regarding the expansion population for the continuation of the Medicaid reform Enhanced Benefit Account program. The state assures Federal CMS that (a) this population retains eligibility under the demonstration solely to access accrued funds in their individual enhanced benefits account for a period of one year; (b) individuals who lose eligibility for Medicaid will receive no other benefits than those available through the EBAP; and (c) this population is limited to individuals who have accrued funds in an individual enhanced benefit account. The state assures Federal CMS upon implementation of the MMA program, recipients who have accrued credits under Medicaid Reform will be able to access those credits for up to one year. The state has identified these individuals as demonstration Population A.

65. Healthy Behaviors Programs Under the MMA Program. Through its procurement process, the state must require the managed care plans operating in the MMA program counties 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.

a) The state must monitor to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse treatment plan that meet all state requirements.

b) Programs administered by plans must 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**.**

The state has complied with this term and condition regarding the Healthy Behaviors program to be operated by the MMA plans under the MMA program when implemented. The state assures Federal CMS that the plans, by contract, are required to operate Healthy Behaviors programs to encourage and reward healthy behaviors of their enrollees. The state assures for the Medicare and Medicaid recipients who are enrolled in both an MMA plan and a Medicare Advantage plan, the MMA plan will coordinate their Healthy Behaviors programs with the Medicare Advantage plan to ensure proper coordination. The state also assures Federal CMS it will monitor the MMA plans to ensure, at a minimum, the plans implement a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse treatment plan that meet all state requirements. The state assures the plan's programs will comply with 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. The state will encourage the plans to seek an advisory opinion from the United States Department of Health and Human Services, Office of Inspector General once the specifics of their Healthy Behaviors programs are determined.

66. Participant Access to Credits Under Medicaid Reform (EBAP) and MMA (Healthy Behaviors Programs).

a) Beneficiaries have access to EBAP accounts under Medicaid Reform as follows:

i. Individuals who are enrolled in a Medicaid Reform plan and who have participated in a state defined activity that promotes healthy behavior and thus have a positive balance;

ii. Individuals who no longer are enrolled in a Medicaid Reform plan (either due to loss of eligibility or change of eligibility to an eligibility group not authorized to participate; or transition to a Healthy Behaviors programs through their MMA plan) but who have a positive balance in their account;

iii. Regardless of the reason for the loss of eligibility to participate in the demonstration, an individual participating in EBAP may retain access to any earned funds for a maximum of one year, except in the instance of termination of the demonstration. Upon implementation of the MMA program, recipients who have accrued credits under Medicaid Reform will be able to access those credits for up to one year; and,

iv. If an individual subsequently regains Medicaid eligibility, the enrollee will be eligible to participate in the EBAP and earn additional credits until the MMA program has been implemented in the regional where the individual resides.

b) Beneficiaries have access to Healthy Behaviors accounts under MMA as follows: Managed care plans will not be required to transfer earned credits or rewards or provide access to earned credits or rewards if a beneficiary changes managed care plans. For beneficiaries who lose Medicaid eligibility, plans will be required to maintain record of the credits for 180 days and re-instate earned credits or rewards if the beneficiary re-establishes eligibility and re-enrolls with the plan within 180 days.

The state has complied with this term and condition. The state reports on the Enhanced Benefit Account program in the quarterly report which is submitted 60 days after the end of each quarter and in the annual report which is submitted 120 days after the end of each demonstration year.

67. Federal Financial Participation (FFP) Under Both Medicaid reform and MMA Program. 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.

The state has complied with this term and condition regarding the federal financial participation under the Medicaid reform program and will continue to comply with this requirement under the MMA program.

68. Enhanced Benefits Account Program Contracts Under Medicaid Reform. 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.

The state has complied with this term and condition and has submitted the contract to Federal CMS Regional Office for approval.

69. Effective and Efficient Administration of the Enhanced Benefits Accounts Program Under Medicaid Reform and the Healthy Behaviors programs under the MMA Program. The state will submit documentation related to EBAP and Healthy Behaviors 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 XVI, General Reporting Requirements.

The state has complied with this term and condition with the submission of the quarterly and annual reports.

XIII. Additional Programs

70. Transition of two current 1915(b)(3) programs and one state plan program.

On January 1, 2014 programs currently authorized under Florida's Section 1915(b) Medicaid Managed Care Waiver, will expire and instead be authorized under this demonstration. These programs will be available in all parts of the state.

a) The Healthy Start Program - authorized as 1915(b)(3) services under Florida's Section 1915(b) Medicaid Managed Care Waiver;
b) The Program for All Inclusive Care for Children (a component of the Children's Medical Services Network) – authorized as 1915(b)(3) services under Florida's Section 1915(b) Medicaid Managed Care Waiver; and
c) The Comprehensive Hemophilia Program authorized as state plan covered service under Florida's Section 1915(b) Medicaid Managed Care Waiver.

The state will transition these programs on January 1, 2014 in compliance with this term and condition.

71. Healthy Start Program. The Healthy Start program is available statewide for eligible Medicaid recipients. The Healthy Start program is comprised of the following two components:

(a) **MomCare**: includes outreach and case management services for all women presumptively eligible and eligible for Medicaid under SOBRA. The MomCare component is mandatory for these women as long as they are eligible for Medicaid, and offers initial outreach to facilitate enrollment with a qualified prenatal care provider for early and continuous health care, Healthy Start prenatal risk screening and WIC services. Recipients may disenroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources, family planning

services, Medicaid coverage for the infant and the need to select a primary care physician for the infant.

(b) **Healthy Start Coordinated System of Care**: includes outreach and case management services for eligible pregnant women and children identified at risk through the Healthy Start program. These services are voluntary and are available for all Medicaid pregnant women and children up to the age of 3 who are identified to be at risk for a poor birth outcome, poor health and poor developmental outcomes. The services vary, dependent on need and may include: information, education and referral on identified risks, assessment, case coordination, childbirth education, parenting education, tobacco cessation, breastfeeding education, nutritional counseling and psychosocial counseling. The goal of this component is to increase the intensity and duration of service to Healthy Start beneficiaries.

The state assures Federal CMS the Healthy Start program will be operated in compliance with state law and this term and condition of the waiver.

72. Program for All Inclusive Care for Children (Children's Medical Services Network).

Participation in the PACC program is voluntary. The PACC program provides the following pediatric palliative care support services to children enrolled in the CMS Network who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider (PCP).

a) Support Counseling – Face-to-face support counseling for child and family unit in the home, school or hospice facility, provided by a licensed therapist with documented pediatric training and experience.
b) Expressive Therapies – Music, art, and play therapies relating to the care and treatment of the child and provided by registered or board certified providers with pediatric training and experience.
c) Respite Support – Inpatient respite in a licensed hospice facility or in-home respite for patients who require justified supervision and care provided by RN, LPN, or HHA with pediatric experience. This service is limited to 168 hours per year.
d) Hospice Nursing Services – Assessment, pain and symptom management, and in- home nursing when the experience, skill, and knowledge of a trained pediatric hospice nurse is justified.
e) Personal Care – This service is to be used when a hospice trained provider is justified and requires specialized experience, skill, and knowledge to benefit the child who is experiencing pain or emotional trauma due to their medical condition.
f) Pain and Symptom Management – Consultation provided by a CMS Network approved physician with experience and training in pediatric pain and symptom management.

Bereavement and volunteer services are provided but are not reimbursable services.

The state assures Federal CMS the Program for All-Inclusive Care for Children will be operated as specified in state law and this term and condition of the waiver.

73. Comprehensive Hemophilia Disease Management Program. The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized

service whereby recipients who have a diagnosis of hemophilia or von Willebrand disease and are enrolled in the fee-for-service (FFS) system, the MediPass program (the MediPass program will be terminated with the implementation of the MMA program), FFS PSN, capitated PSN or an HMO, are required to obtain pharmaceutical services and products related to factor replacement therapy from one of the two contracted vendors. In addition to product distribution, the program provides pharmacy benefit management, direct beneficiary contact, personalized education, enhanced monitoring, and direct support of beneficiaries in the event of hospitalization, at no additional cost to the state. Enrollees have access to a registered nurse and licensed pharmacist 24 hours a day, seven days a week. The enrollees also have access to medical care and treatment through their usual and customary networks, with no restrictions on services or providers, and receive pharmacy products other than those related to factor replacement therapy via the usual and customary networks without restriction, as well.

The populations enrolled in the program have a diagnosis of hemophilia, are currently Medicaid eligible, receive prescribed drugs from the therapeutic MOF Factor IX, and MOE-Antihemophilic Factors, Corifact (MOC therapeutic class), Stimate (P2B therapeutic class), and other therapeutic classes identified by the Agency as treatment for hemophilia or von Willebrand; are in the FFS system, MediPass program (the MediPass program will be terminated upon implementation of the MMA program), FFS PSN, HMO or capitated PSN. Medicaid-Medicare eligible individuals may voluntarily enroll in the program.

The state assures Federal CMS the Comprehensive Hemophilia Management program will be operated as specified in state law and this term and condition of the waiver.

XIV. Low Income Pool

74. 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 84(a). The LIP consists of a capped annual allotment of $1 billion total computable for each year of the demonstration extension.

The state has complied with this term and condition regarding the definition of Low Income Pool. The Florida Legislature continues to provide necessary budget authority and direction to utilize the $1 billion per year of the demonstration.

75. 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 LIP payments or through disallowance. 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.

The state has complied with this term and condition regarding availability of LIP Funds. The state maintained the LIP program during this waiver period and has expended funds in accordance with the terms and conditions of the waiver. The state acknowledges that LIP dollars that are lost as a result of penalties or recoupment are surrendered by the state and not recoverable.

76. 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 October 2012. 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 4. The state submitted to CMS Reconciliations for DY 5 on May 31, 2013.

CMS has determined that payments made to providers in DY 1-3 are in excess of allowable costs; therefore, the state is required to return the federal portion of $104,351,578 total computable expenditures claimed in excess of allowable cost and/or in excess of applicable cost limits. This will be achieved through a reduction of the amount available to be claimed under the pool by $104 million the first year of the state's intended renewal period in the event the demonstration is renewed or, by issuing a disallowance to the state.

If the reconciliations for DY 4 identify LIP payments in excess of allowable cost consistent with paragraph 75 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 the next demonstration year. 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 approved 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 one demonstration year.

DY 4 and 5 reconciliation results will be reflected in the Reimbursement and Funding Methodology documents for DY 9 and 10. If the final reconciliations for DY 4 and 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 the next demonstration year 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 75 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 the next demonstration year's LIP payments.

The state shall by February 1 of each year of the demonstration, 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 74 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.

The state has complied with this term and condition regarding the Reimbursement and Funding methodology document. The state submitted an updated protocol January 29, 2013 in accordance with this term and condition. This updated document ensures the payment methodologies for the distributing the LIP funds to providers supports the goals of the LIP as described in term and condition 74.

77. 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).

The state has complied with this term and condition regarding LIP permissible expenditures. As of demonstration year 8, there were payments made for each of the provider and program types provided in the terms and conditions of the waiver. The state submits required LIP program information in the quarterly and annual reports as specified in term and condition 90 and 91.

78. 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.

The state has complied with this term and condition regarding LIP expenditures related to non-qualified aliens. The state does not use LIP funds for cost associated with the provisions of health care for non-qualified aliens. Allowable cost for LIP funds are defined in the approved Reimbursement and Funding Methodology document, approved October 16, 2012.

79. 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 76.

To date, the state has not executed the policies provided in this term and condition. The state reserves the right to use this authority as appropriate and permitted under this term and condition.

80. 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.

The state has complied with this term and condition regarding LIP permissible hospital expenditures. The state requires all hospital LIP participating providers to complete a LIP cost limit to ensure that providers do not receive LIP payments in excess of the cost of providing health care to the Medicaid, uninsured and underinsured populations. The requirements and calculation of the cost limit are defined and detailed in the approved Reimbursement and Funding Methodology document approved on October 16, 2012.

81. 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.

The state has complied with this term and condition regarding LIP permissible non-hospital based expenditures. The state requires all non-hospital LIP participating providers to complete a LIP cost limit to ensure that providers do not receive LIP payments in excess of the cost of providing health care to the Medicaid, uninsured and underinsured populations. The requirements and calculation of the cost limit are defined and detailed in the approved Reimbursement and Funding Methodology document approved on October 16, 2012.

82. 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.

The state has complied with this term and condition regarding LIP permissible sources of funding criteria.

XV. Low Income Pool Milestones

83. 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 84 and 85, 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.

The state has complied with this term and condition regarding the aggregate LIP funding. The state has not been assessed penalties for noncompliance of LIP milestones set forth in the terms and conditions of the waiver.

84. 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, 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.

e) Timely submission of all other reporting requirements under Sections XVI, General reporting Requirements, XIX, Evaluation of the Demonstration and XX, Measurement of Quality of Access to Care and Improvement.

f) 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.

The state has complied with all parts of this term and condition. Term and condition 84 (Tier-One Milestone) required the state to release $50 million in LIP funding in accordance with CMS' Three-Part Aim. On July 4, 2012, the state posted a bid for providers to participate in the Tier-One milestone distribution. After review the applications, the state awarded the Tier-One Milestone funding on September 28, 2012. The Tier-One providers provided the required quarterly reporting to the state as part of the monitoring of each programs progress. On January 14, 2012, the state submitted a schedule to Federal CMS that included reconciliation submission dates for federally qualified health centers and the county health departments. The state has provided all required reporting timely as required by term and condition 84 (c) and 84 (e) of the waiver.

The state also submitted templates for the Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report" to Federal CMS on March 31, 2012 as required. The first annual Milestone Statistics and Findings Report was submitted to Federal CMS on April 1, 2013.

The state has not received any penalties for the Tier-One Milestone data for Demonstration Year 7.

85. Tier-Two Milestones. Tier-two milestones initiatives must drive from the three overarching goals of the Three-Part Aim as described in paragraph 84(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 110(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.

The state has complied with this term and condition (Tier-Two Milestone) regarding the 15 hospitals which are allocated the largest annual amounts in LIP funding in a demonstration year. Hospitals were required to select and participate in three quality initiatives based on CMS' Three-Part Aim as described in term and condition 84(a). The state and Federal CMS worked collaboratively to finalize the submission procedures for the hospital's health care initiatives including the specific quality initiatives, investments, activities, the applicable standards, measures, evaluation measures and protocols to be used for implementation and monitoring. On January 18, 2012, the state submitted a template to be used by the top 15 hospitals to Federal CMS for review. CMS approved the template on February 22, 2012 and extended the due date for the top 15 to complete the templates to April 9, 2012. The state received 44 proposals from the top 15 providers on April 9, 2013 including baseline data and outcome targets; the state forwarded the proposals to Federal CMS on April 10, 2012. The state submitted recommendations on the 44 initiatives to Federal CMS April 27, 2012. Federal CMS emailed agreeing with the state's review of all initiatives on May 9, 2012. The state obtained final approval from Federal CMS on June 29, 2012. On January 4, 2013, the state received a letter from Federal CMS stating that no penalties would be assessed; all Tier-Two Milestones had been met.

XVI. General Reporting Requirements

86. General Financial Requirements. The state must comply with all general financial requirements set forth in Section XVII.

The state has complied with all general financial requirements set forth in Section XVII of the waiver.

87. Reporting Requirements Relating to Budget Neutrality. The state must comply with all reporting requirements set forth in Section XVIII.

The state has complied with all reporting requirements set forth in Section XVIII of the waiver.

88. 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 438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

a) Encounter Data (Health Plan Responsibilities) – The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.

b) Encounter Data (State Responsibilities) - The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, 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. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

c) Encounter Data Validation Study for New Capitated Managed Care Plans - 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.

d) Submission of Encounter Data to CMS - The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed 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.

The state has complied with this term and condition regarding managed care data requirements. In accordance with 42 CFR 438.242 and for programmatic purposes, the state includes in every health plan contract, the requirements and standards that govern the collection, maintenance, validation and submission of encounter data. At least yearly, the state reviews and updates the contracts to refine the encounter data submission requirements. The state reports on encounter data in the quarterly and annual reports submitted to Federal CMS in compliance with term and condition 90 and 91.

The state designed and developed encounter data processing capabilities as a component of its Medicaid Management Information System (MMIS). Plans submit encounter data to the MMIS which validates the accuracy of encounter data at two levels. First, the encounter data is edited for compliance with national ANSI transaction standards for syntax and field completion, and secondly, it is validated for compliance with programmatic standards. At each level, the system reports the deficiencies identified in the data to the plans, which are required by contract to correct and resubmit deficiencies in the data.

Once the system validates the encounter data submissions, information contained in the data is available for analysis by state staff to determine its conformance with contractual requirements for completeness, accuracy and timeliness. The results of the analysis are distributed on a monthly basis to the plans and to state staff in a Compliance Report. Plans that fail to meet the contractual standards may be fined or sanctioned in accordance with the plan contract.

The Compliance Reports also serve as a mechanism for prompting both the plans and the state to evaluate the encounter data and to discuss corrective action strategies, when applicable, to promote more complete and reliable encounter data.

As an additional measure to validate and improve encounter data submissions, the state has contracted with the state's external quality review organization, to review encounter data. A component of the encounter data review includes a comparison of the submitted encounter data to the corresponding medical record.

All plans are required to submit encounter data upon initiation of their contract. A new plan's encounter data is evaluated on a monthly basis for completeness, timeliness, and accuracy along with all other plans. While no plans have met the 18 month milestone yet, the state has a process that will identify plans that do. At that time, the plans will be referred to the state's external quality review organization for inclusion in their medical record review.

89. Monitoring Calls. During the implementation phase of the MMA program, CMS will schedule weekly implementation calls that will continue until at least 60 days after the last region is implemented. The state and CMS shall jointly develop the agenda for the calls.

a) 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, health plan operations (such as contract amendments, rate certifications, plans withdrawing or entering the demonstration), health care delivery, enrollment, quality of care, access, benefit packages including EPSDT, dental care, the Enhanced Benefits Account Program (until MMA program is implemented), Healthy Behaviors Programs, 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.

The state has complied with this term and condition regarding monitoring calls with Federal CMS to discuss significant developments affecting the demonstration and as specified.

90. 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. As described in STC 94(d)(iv), reports on the state's progress in developing the necessary CMS-64 reporting system changes to accommodate the MMA program, should the 1115 demonstration be renewed

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; quality of care; access; pertinent legislative or litigation activity; and other operational issues; A discussion of network adequacy reporting from medical and dental plans including customer service reporting; average speed of answer at the plans and

call abandonment rates; summary of capitated managed care plan and FFS PSNs appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of the managed care plans critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation;

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 and MMA Program counties including the number of beneficiaries who made an affirmative choice verses being auto-enrolled into a plan;
h) Efforts to promote alignment and integration with Medicare for Medicare-Medicaid eligible individuals, including the number of participants who are in an MMA plan and an affiliated Medicare Advantage plan.
i) Documentation of the efforts to promote full and timely access to medical, vision, hearing, dental, mental health, and other care and services covered under the EPSDT benefit for children, as well as services required by the Florida Department of Children and Families for foster care children.
j) Low Income Pool activities and associated expenditures;
k) Activities related to choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups;
l) Participation rates in the Enhanced Benefits Account Program until implementation of the MMA program and the Healthy Behaviors Programs after MMA implementation. 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;
m) Status of managed care plan performance, initiatives and activities, as measured by HEDIS, CAHPs and other quality metrics;
n) Description of the implementation progress of expanding managed care, challenges encountered, and how the challenges were addressed;
o) Progress toward the demonstration goals; and,
p) Evaluation activities including the contracting status with an independent evaluator.

The state has complied with the quarterly reporting requirements specified in this term and condition of the waiver.

91. Annual Report. The state must submit an annual report no later than 120 days after the close of each DY. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

The report must 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 90 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. In addition, the annual report must address the following items.

a) Yearly enrollment reports must be included for all demonstration enrollees for each demonstration year (DY) that include the member months, as required to evaluate compliance with the budget neutral agreement, and the total number of unique enrollees within the DY.
b) Pursuant to STC 118, the state must report on the implementation and effectiveness of the updated Comprehensive Quality Strategy as it impacts the demonstration.
c) Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups,

   annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and managed care plan compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure.
d) Medicare-Medicaid Eligible Enrollees. The state must report on the efforts to promote alignment and integration with Medicare for dual-eligible individuals.
e) Children including foster care children. The state must report on the efforts to promote full and timely access to medical, vision, hearing, dental, mental health and other care and services covered under the EPSDT benefits for children, as well as services required by the Florida Department of Children and Families for foster care children.
f) Managed Care Expansion. The state must report on the implementation progress, challenges encountered, and how the challenges were addressed, as specified in section X, Consumer Protections.
g) Evaluation. The state must report on the contracting status with an independent evaluator.

The state has complied with the annual reporting requirements specified in this term and condition of the waiver.

92. 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 90. On June 24, 2012, the state notified CMS that a transition was not applicable to the demonstration.

The state notified Federal CMS by electronic mail that a transition plan would not be applicable to this demonstration because there are no demonstration populations who will need to transition to a coverage option under the Affordable Care Act on June 22, 2012.

XVII. General Financial Requirements

93. 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 XIV.

The state has and continues to comply with this term and condition of the waiver regarding quarterly expenditure reports. The state submits quarterly expenditure reports using the Form CMS 64 to report total expenditures for the Medicaid program, including expenditures provided through the demonstration under Section 1115 waiver authority. The expenditures for the demonstration under Section 1115 waiver authority do not exceed the pre-defined limits on the costs incurred under the demonstration.

94. 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. In addition to reporting through the CMS-64 the state's expenditures on dental care, the state must also report on spending on dental care through the health plans.

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. **Through June 30, 2014, the current MEGs (MEG 1:** SSI**, MEG 2:** TANF, **MEG 3:** Low Income Pool) with the following currently approved population mappings will be utilized for the CMS-64 reporting purposes. Demonstration Populations 1 and 7 represent Reform counties and include all enrolled mandatory and voluntary participants. Populations 2 through 5 represent non-reform counties and include all individuals who would be mandatory participants if Reform was effective in that county.

(A) **Demonstration Population 1 (MEG 1)** – (Aged/Disabled): Aged and disabled demonstration enrollees.

(B) **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.

(C) **Demonstration Population 3 (MEG 2)** – (FMR-TANF): Individuals qualifying under TANF in non-Reform counties who would be required to enroll in the demonstration.

(D) **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.

(E) **Demonstration Population 5 (MEG 1)** – (FMR->65): Individuals 65 and older in non-Reform counties who would be required to enroll in the demonstration.

(F) **Demonstration Population 6 (MEG 3)** – (Low Income Pool): Demonstration expenditures allowed under the Low Income Pool.

(G) **Demonstration Population 7 (MEG 2)** – (TANF & related grp): TANF demonstration enrollees.

ii. Beginning no earlier than January 1, 2014, expenditures associated with mandatory and voluntary MMA enrollees will be reported using the currently approved classification as defined in (i) above.

iii. **If the 1115 Research and Demonstration Waiver is renewed,** the CMS-64 will reflect the expenditures for statewide MMA populations, including those attributable to MMA voluntary populations. The following names and definitions will be utilized for the CMS-64 reporting purposes:

(A) MEG 1: SSI

(B) MEG 2: TANF

(C) MEG 3: Low Income Pool

At this time, the CMS-64 will reflect the expenditures for statewide MMA populations, including those attributable to MMA voluntary populations.

iv. Progress Reports. The state must submit quarterly progress reports on its progress in developing new programming logic to accommodate the necessary CMS-64 reporting system changes, should the 1115 demonstration be renewed.

e) Excluded Services. The following services are excluded from the demonstration:

i. ID Waiver (HCBS Waiver Services);

ii. Home Safe Net (Behavioral Services) until the MMA program is implemented;

iii. Behavioral Health Overlays Services (Services Only) until the MMA program is implemented;

iv. ICF/IID Institutional Services;

v. Family & Supported Living Waiver Services;

vi. Katie Beckett Model Waiver Services;

vii. Brain & Spinal Cord Waiver Services; and

viii. School Based Admin Claiming.

f) Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance of 100 percent for claimed the amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may exclude from the budget neutrality test for this demonstration the portion of the increase for which the federal government pays 100 percent. These amounts should be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

g) 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.

h) 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.

i) 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.

The state reports expenditures subject to the budget neutrality cap in accordance with the provisions of this term and condition of the waiver. Expenditures subject to the budget neutrality cap include all Medicaid expenditures on behalf of demonstration eligibles, except expenditures for services excluded as listed in term and condition #94(e).

Demonstration expenditures and administrative costs are reported through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES). Under the design of Florida Medicaid Reform, there is a period of transition in which eligibles continue to receive services through Florida's 1915(b) Managed Care Waiver programs. The expenditures for those not enrolled in the 1115 Medicaid Reform Waiver but eligible for Medicaid Reform and enrolled in Florida's 1915(b) Managed Care Waiver are subject to both the monitoring of the 1915(b) Managed Care Waiver and the 1115 Medicaid Reform Waiver. To identify these eligibles, additional Medicaid Eligibility Groups (MEGs) have been added to the 1115 Medicaid Reform Waiver templates for monitoring purposes.

Expenditures for the Demonstration are reported on the Form CMS 64 under Waiver Number 11W00206/4 using a separate template for each Florida Medicaid Reform eligibility group (MEG) for each demonstration year. The MEGs included on the Form CMS 64 and the Waiver Name used on the Form CMS 64.9 Waiver and Form CMS 64.9P Waiver are as follows:

MEG	*Waiver Name on MBES/CBES*
SSI	*Aged/Disabled*
TANF	*TANF & related groups*
Low Income Pool	*Low-Income Pool*
Managed Care Waiver SSI – No Medicare	*FMR-SSI+DsEldw/oMcare*
Managed Care Waiver TANF	*FMR-TANF*
Managed Care Waiver SOBRA and Foster Children	*FMR-SOBRA/FC*
Managed Care Waiver Age 65 and Older	*FMR->65*
Administrative Cost	*ADM*

The State will continue to report waiver costs and populations as defined in term and condition #94(d)(i), which includes mandatory and voluntary enrollees.

During the MMA transition enrollment time period, the state will continue to utilize its current Form CMS 64 reporting operation. During the MMA transitional period, the state will provide supplemental reports to CMS on those demonstration actual waiver costs and enrolled member months not already represented in the MEGs defined in #94(d)(i). This will be performed in accordance with term and condition #95(c) and #106(b).

The state will include in the Florida Medicaid Reform Quarterly Progress Report and the Florida Medicaid Reform Annual Report the status towards development of the new system application that will be necessary for the Form CMS 64 report with the full statewide implementation of the MMA demonstration waiver and the close-out of Florida's 1915(b) Managed Care Waiver. This progress reporting will commence with the October-December 2013 quarterly report.

95. 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 90, the actual number of eligible member months for the three MEGs described in paragraph 106 the state must provide CMS, upon request, eligible member months by population as defined in paragraph 94(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.

c) Starting January 1, 2014, the state must begin reporting separate member month totals for mandatory and voluntary individuals enrolled in MMA that are not already represented in the member month reporting in place prior to that date. The member months must be subtotaled according to the MEGs defined in subparagraph (d)(i) above.

The state reports member months subject to the budget neutrality cap in accordance with the provisions of term and condition #95. The state provides the actual number of eligible member months for the demonstration eligibles as defined in term and condition #95(b). The state certifies the accuracy of the member month figures in the above reports.

96. 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.

The state complies with term and condition #96 by estimating the matchable Medicaid expenditures on the quarterly Form CMS 37, and the state submits Form CMS 64 quarterly Medicaid expenditure report for each quarter of the Demonstration.

97. 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.

Pursuant to standard Medicaid financing rules, FFP is excluded for payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution) pursuant to the payment exclusion in paragraph (A) following section 1905(a)(29) of the Act.

In addition, pursuant to standard Medicaid financing rules, FFP is excluded for payments with respect to care or services for any individual who has not attained 65 year of age and who is a patient in an institution for mental diseases pursuant to the payment exclusion in paragraph (B) following section 1905(a)(29) of the Act, except as provided in section 1905(a)(16) for inpatient psychiatric services for individuals under age 21.

The state provides Federal CMS with copies of the State's General Appropriations Act for each State fiscal year to show the source of the non-Federal share of expenditures. The state, through Form CMS 37, Form CMS 64, the Florida Medicaid Reform Quarterly Progress Report, and the Florida Medicaid Reform Annual Report, provides the net expenditures matchable for Federal financial participation. The state complies with Federal CMS provisions relating to the reporting of the expenditures listed in term and condition #97.

98. 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.

The state complies with term and condition #98 relating to the use of State/local monies as certified matching funds.

99. 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.

The state complies with term and condition #99 relating to the use of State/local monies as certified matching funds.

100. MSIS Data Submission. The state shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards, including the required transition to T-MSIS.

The state complies with term and condition #100. MSIS data is submitted electronically to CMS in accordance with Federal CMS requirements and timeliness standards.

101. Monitoring the Demonstration. The state must provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

The state will provide upon request to Federal CMS the information necessary to monitor the demonstration's effectiveness, in a reasonable time period.

102. 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.

The state operates a detailed SQL application that distinctly separates costs and Medicaid populations by its various Section 1115 waivers and Section 1915(b) Managed Care Waiver. These distinct calculations are defined in the State's Form CMS 64, the Florida Medicaid Reform Quarterly Progress Report, and the annual report for this waiver.

XVIII. 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 103 and 104 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 94. 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.

The state complies with the monitoring of budget neutrality through quarterly extracts of Demonstration expenditures and member months.

Demonstration eligibles, enrollee member months, and related claims data for included services are identified using a query of SQL tables built from claims and eligibility data extracted from the Florida Medicaid Management Information System.

The claims data and member months are separated into appropriate categories or Medicaid Eligibility Groups (MEGs) to report on the waiver forms of the Form CMS 64.

Using the paid claims data extracted, the included expenditures for each MEG are identified by service type and reported on the appropriate line on the Form CMS 64.9 Waiver or Form CMS 64.9P Waiver.

Included expenditures that are also identified as Home and Community-Based Waiver Services (HCBS) are identified and the corresponding HCBS waiver template on the Form CMS 64 is adjusted to reflect the hierarchy of the 1115 waiver reporting.

All identified expenditures for waiver and non-waiver services in total are checked against expenditure reports that are generated by the FMMIS and provided to the Agency's Finance and Accounting unit which certifies and submits the Form CMS 64 report.

103. 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.

The state complies with the budget neutrality limit and spending provisions for the Low Income Pool, and expenditures do not exceed the total computable limit.

104. 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 94 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.

The state complies with the budget neutrality limit under the Per Capita Cost Per Month method as of the quarter ending September 30, 2013.

The following is a summary of the annual actual PCCM by MEG compared to the targeted PCCM under the terms and conditions for budget neutrality:

For Demonstration Year One, MEG 1 has a PCCM of $972.13 compared to WOW of $948.79 which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 compared to WOW of $199.48 which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,022.14 compared to WOW of $1,024.69 (which is 99.75% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.85 compared to WOW of $215.44 which is 78.84% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $1,057.86 compared to WOW of $1,106.67 which is 95.59% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.96 compared to WOW of $232.68 which is 71.76% of the target PCCM for MEG 2.

For Demonstration Year Four, MEG 1 has a PCCM of 1077.30 compared to WOW of $1,195.20 which is 90.14% of the target PCCM for MEG 1. MEG 2 has a PCCM of $166.91 compared to WOW of $251.29 which is 66.42% of the target PCCM for MEG 2.

For Demonstration Year Five, MEG 1 has a PCCM of $1,096.59 compared to WOW of $1,290.82 which is 84.95% of the target PCCM for MEG 1. MEG 2 has a PCCM of $167.11 compared to WOW of $271.39 (Table 30), which is 61.58% of the target PCCM for MEG 2.

For Demonstration Year Six, MEG 1 has a PCCM of $1,104.25 compared to WOW of $1,356.65 which is 81.40% of the target PCCM for MEG 1. MEG 2 has a PCCM of $176.09 compared to WOW of $285.77 which is 61.62% of the target PCCM for MEG 2.

For Demonstration Year Seven, MEG 1 has a PCCM of $1,084.72 compared to WOW of $1,425.84 which is 76.08% of the target PCCM for MEG 1. MEG 2 has a PCCM of $178.08 compared to WOW of $300.92 which is 59.18% of the target PCCM for MEG 2.

For Demonstration Year Eight (July-Sept. 2013), MEG 1 has a PCCM of $862.36 compared to WOW of $1,498.56 which is 57.55% of the target PCCM for MEG 1. MEG 2 has a PCCM of $152.52 compared to WOW of $316.87 which is 48.13% of the target PCCM for MEG 2.

The combined annual PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the terms and conditions are also weighted using the actual case months. The following is the combined annual PCCM compared to the PCCM targets:

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $314.60. Comparing the calculated weighted averages, the actual PCCM is 89.15% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $309.27. Comparing the calculated weighted averages, the actual PCCM is 83.07% of the target PCCM.

For Demonstration Year Four, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs is $386.76. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $297.57. Comparing the calculated weighted averages, the actual PCCM is 76.94% of the target PCCM.

For Demonstration Year Five, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs is $413.05. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $296.27. Comparing the calculated weighted averages, the actual PCCM is 71.73% of the target PCCM.

For Demonstration Year Six, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs is $432.81. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM is $303.54. Comparing the calculated weighted averages, the actual PCCM is 70.13% of the target PCCM.

105. 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.

The state acknowledges that it is at risk for the average per capita cost of the demonstration enrollees, but is not at risk for the number of demonstration enrollees.

106. 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 94(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 95.

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. The PMPM estimates for SSI MEG and TANF MEG are applied to the member months reported based on the standards in place as of June 2013. The PMPM estimates for SSI MEG and TANF MEG are applied to the member months reported for MMA enrollees, discussed in paragraph 95(c).

Demonstration Year	SSI MEG	Trend Rate	TANF MEG	Trend Rate	SSI MEG MMA	TANF MEG MMA
DY 1 (SFY 2007)	$ 948.79	8.0%	$199.48	8.0%		
DY 2 (SFY 2008)	$1,024.69	8.0%	$215.44	8.0%		
DY 3 (SFY 2009)	$1,106.67	8.0%	$232.68	8.0%		
DY 4 (SFY 2010)	$1,195.20	8.0%	$251.29	8.0%		
DY 5 (SFY 2011)	$1,290.82	8.0%	$271.39	8.0%		
DY 6 (SFY 2012)	$1,356.65	5.1%	$285.77	5.3%		
DY 7 (SFY 2013)	$1,425.84	5.1%	$300.92	5.3%		
DY 8 (SFY 2014)	$1,498.56	5.1%	$316.87	5.3%	$294.01	$583.64

The state complies with term and condition #106. The state is within the projected PCCM cap and does not exceed budget neutrality. Please see the response to term and condition #104.

107. How the Limit will be Applied. The limits as defined in paragraphs 103 through 106 will apply to the actual expenditures for the demonstration, as reported by the state under Section XVIII. 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.

The state complies with term and condition #107. The state monitors the PCCM through quarterly data extracts to monitor budget neutrality. The resulting PCCMs based on actual expenditures and member months are reported through the Form CMS 64, the Florida Medicaid Reform Quarterly Progress Report, and the Florida Medicaid Reform Annual Report.

108. 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.

The state acknowledges that Federal CMS reserves the right to adjust the budget neutrality ceiling and budget targets based on the impermissible conditions stated in term and condition #108.

109. 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 91. 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.

Year	Cumulative target definition	Percentag
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

The state is in compliance with term and condition #109. Over the course of the Demonstration, the state has not exceeded the cumulative target PCCM. The state calculates an annual expenditure target for each completed year and reports it to Federal CMS as part of the Florida Medicaid Reform Quarterly Progress Report and the Florida Medicaid Reform Annual Report. Please see the responses to term and condition #104 and term and condition #106 for additional information.

XIX. Evaluation of the Demonstration

110. Submission of Draft Evaluation Design Update. The state must submit to CMS for approval, within 120 days of the approval date of the MMA amendment, a draft evaluation design update that builds and improves upon the evaluation design that was approved by CMS on October 31, 2012. At a minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in paragraph 112). The updated design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. The updated design should accommodate and reflect the staggered implementation of the MMA program to produce more reliable estimates of program impacts. The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data;

controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

The updated design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of 112(a), is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph above. The rigor also described above also applies as appropriate throughout Sections XIX and XX.

The state submitted the draft evaluation design to Federal CMS on October 11, 2013 in compliance with this term and condition of the waiver.

111. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the evaluator selected by HHS. The state shall submit the required data to HHS or its contractor.

The state will work cooperatively with HHS evaluators and provide all requested data upon request in accordance with this terms and conditions of the waiver.

112. Evaluation Design.

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 (EBAP) and the MMA plans' Healthy Behaviors programs (upon implementation of the MMA 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;

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;

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

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

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

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

b) Measures. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:

i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);

ii. The measure steward;

iii. The baseline value for each measure;

iv. The sampling methodology for assessing these outcomes; and

v. The methods of data collection.

c) Sources of Measures. CMS recommends that the state use measures from nationally- recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

d) The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. 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

The state complied with this term and condition with the submission of the draft evaluation design submitted October 11, 2013.

113. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design and the draft MMA evaluation strategy 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 final report by October 31, 2014. The state must submit the final evaluation report within 60 days after receipt of CMS' comments.

The state must submit to CMS a draft of the evaluation final report by October 31, 2014. The final report must include the following:

a) An executive summary;
b) A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;
c) A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;
d) A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);
e) Final evaluation findings, including a discussion of the findings (interpretation and policy context); and
f) Successes, challenges, and lessons learned.

The state will submit the final evaluation report as specified in this term and condition.

XX. Measurement of Quality of Care and Access to Care Improvement

114. External Quality Review (EQR). The state is required to meet all requirements for external quality review (EQR) found in 42 C.F.R. Part 438, subpart E. In addition to routine encounter data validation processes that take place at the MCO/PIHP and state level, the state must maintain its contract with its external quality review organization (EQRO) to require the independent validation of encounter data for all MCOs and PIHPs at a minimum of once every three years.

The state should generally have available its final EQR technical report to CMS and the public, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), by April 30th of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary of Health and Human Services each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

The state is in compliance with this term and condition regarding the External Quality Review Reporting and submission of required data by September 30th of each year. The state's external quality review organization contract was submitted to Federal CMS to ensure all requirements for external quality review (EQR) found in 42 C.F.R. Part 438, subpart E are met.

115. Consumer Health Plan Report Cards. On an annual basis, the state must create and make readily available to beneficiaries, providers, and other interested stakeholders, a health plan report card, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), that is based on performance data on each health plan included in the annual EQR technical report. Each health plan report card must be posted on the state's website and present an easily understandable summary of quality, access, and timeliness regarding the performance of each participating health plan. The report cards must also address the performance of subcontracted dental plans.

The state will create and make readily available to recipients, providers, and other interested stakeholders, a health plan report card, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), that is based on performance data on each health plan included in the annual EQR technical report. Each managed care plan report card will be posted on the Agency's website and presented an easily understandable summary of quality, access, and timeliness regarding the performance of each participating health plan. The report cards will also address the performance of subcontracted dental plans.

116. Performance Improvement Projects (PIPs). The state must require each health plan to commit to improving care in the following focus areas, which have the significant potential for achieving the demonstration's goals of improving patient care, population health, and reducing per capita Medicaid expenditure.

a) A PIP combining a focus on improving prenatal care and well-child visits in the first 15 months;

b) A PIP focused on preventive dental care for children;

c) An administrative PIP, topic of which must be approved by the state; and

d) A choice of PIP in one of the following topic areas:

   a. Population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that have been identified as in need of improvement;

   b. Integrating primary care and behavioral health; and

   c. Reducing preventable readmissions.

e) Each PIP must be conducted in accordance with 42 C.F.R. §§ 438.358 and 438.240. The state must incorporate these PIP requirements into its MMA managed care plan contracts upon implementation of the MMA program.

The state is in compliance with this term and condition regarding performance improvement projects. The state requires each health plan to commit to improving care in the following focus areas, which have the significant potential for achieving the demonstration's goals of improving patient care, population health, and reducing per capita Medicaid expenditure.

a) A PIP combining a focus on improving prenatal care and well-child visits in the first 15 months;
b) A PIP focused on preventive dental care for children;
c) An administrative PIP, topic of which must be approved by the state; and
d) A choice of PIP in one of the following topic areas:

- Population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that have been identified as in need of improvement;
- Integrating primary care and behavioral health; and
- Reducing preventable readmissions.

The state also requires each of the plan's performance improvement project be conducted in accordance with 42 C.F.R. §§ 438.358 and 438.240. The state has incorporated these performance improvement project requirements into its MMA managed care plan contracts.

117. Measurement Activities. The state must ensure that each participating health plan is accountable for metrics on quality and access, including measures to track progress in identified quality improvement focus areas, measures to track quality broadly, and measures to track access. The state must set performance targets that equal or exceed the 75th percentile national Medicaid performance level.

The state must collect data and information on dental care utilization rates, the CMS Medicaid and CHIP adult and child core measures, and must align with other existing federal measure sets where possible to ensure ongoing monitoring of individual well-being and plan performance. The state will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

The state is in compliance with this term and condition regarding measurement activities. The state assures Federal CMS that each participating plan is accountable for metrics on quality and access, including measures to track progress in identified quality improvement focus areas, measures to track quality broadly, and measures to track access. The state has set performance targets that equal or exceed the 75th percentile national Medicaid performance level.

The state collects data and information on dental care utilization rates, the CMS Medicaid and CHIP adult and child core measures, and has aligned with other existing federal measure sets where possible to ensure ongoing monitoring of individual well- being and plan performance. The state uses this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

118. Comprehensive State Quality Strategy. The state shall adopt and implement a comprehensive and holistic, continuous quality improvement strategy that focuses on all aspects of quality improvement in Medicaid, including FFS populations; FFS PSNs ; and capitated managed care plans, including Medicaid Reform, and the MMA program, and managed long term services and supports. The Comprehensive Quality Strategy (CQS) shall meet all the requirements of 42 CFR 438 Subparts D and E and must include section 1915(c) HCBS waivers' corrective action plan quality components.

a) The CQS must also address the following elements:
   i. The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part

aim but should be more specific in identifying specific pathways for the state to achieve these goals.

ii. The associated interventions for improvement in the goals.

iii. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where possible. The metrics should go beyond HEDIS and CAHPS data, and should reflect cost of care.

iv. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, each health plan, and each direct health services provider. The state will work with CMS to further define what types of metrics will be measured for direct service providers.

v. The specific methodology for determining benchmark and target performance on these metrics for each aggregated level identified above (state, plan and provider).

vi. Performance improvement accountability – i.e., the state must determine if the current plans for financial incentives adequately align with the specific goals and targeted performance, and whether enhancements to these incentives are necessary (increased or restructured financial incentives, in-kind incentives, contract management, etc.). The state must present the findings of the determination to CMS.

vii. Specific metrics related to each population covered by the Medicaid program. HCBS performance measures, consistent with the corrective action plan, in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, and assuring there are qualified providers and appropriate HCBS settings.

viii. Monitoring and evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, and also a rigorous and independent evaluation of the demonstration, as described in STC 110. The evaluation should reflect all the programs covered by the CQS as mentioned above.

ix. HIV evaluation. The state will evaluate, in accordance with the rigor described in STC 110, the HIV population to determine if there are better health outcomes for HIV positive beneficiaries in the HIV specialty plan as compared to in a MMA health plan. The state will also evaluate medication adherence and improved care and care coordination as a result of being enrolled in the HIV specialty plan.

b) The CQS should include a timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the re-basing of performance data.

c) The CQS must include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.

d) The first draft of this CQS is due to CMS no later than 120 days following the approval of this amendment/renewal. CMS will review this draft and provide feedback to the state. The state must revise and resubmit the CQS to CMS for approval within 45 days of receipt of CMS comment. The state must revise (and

submit to CMS for review and approval) their CQS whenever significant changes are made to the associated Medicaid programs and the content of the CQS. Revisions to the CQS must be submitted to CMS for review and approval within 90 days of approval of the amendment authorizing the implementation of MMAP.

Any further revisions must be submitted accordingly:

i. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver renewals); and/or
ii. Changes to an existing, approved CQS due to fundamental changes to the CQS must be submitted for review and approval to CMS no later than 60 days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than 60 days following the changes.

e) The state must solicit for and obtain the input of beneficiaries, the Medical Care Advisory Committee (MCAC) as set forth in STC 43, and other stakeholders in the development of its CQS and make the initial CQS, as well as any significant revisions, available for public comment prior to implementation. Pursuant to STC 91, Annual Report, the state must also provide CMS with annual reports on the implementation and effectiveness of their CQS as it impacts the demonstration.

f) As required by 42 C.F.R. §438.360(b)(4), the state must identify in the CQS any standards for which the EQRO will use information from private accreditation reviews to complete the compliance review portion of EQR for participating MCOs or PIHPs. The state must, by means of a crosswalk included in the CQS, set forth each standard that the state deems as duplicative to those addressed under accreditation and explain its rationale for why the standards are duplicative.

g) Upon approval by CMS, the state will finalize the CQS to be fully compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d).

The state is in compliance with this term and condition regarding the state's Comprehensive Quality Strategy. The state submitted the draft Comprehensive Quality Strategy on October 10, 2013 in accordance with the requirements specified in this term and condition. The state held a meeting with the Medical Care Advisory Committee on September 17, 2013 to obtain recommendations for the state's Comprehensive Quality Strategy. The state posted the draft document on its website for public review and comment from September 1, 2013 through September 30, 2013. All comments received were considered in the development of the state's draft Comprehensive Quality Strategy.

IX. Waiver and Expenditure Authorities

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

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

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

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

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Appendices A-F

Appendix A.1
Public Process Strategy

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

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

Appendix A.2
Legislative Activities and Public Workshops

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

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

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

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

Legislative Activities and Public Workshops[7] 1115 Waiver Extension Request (June 10, 2011 – September 30, 2013)			
Date	**Meeting/Presentation**	**Location**	**Link to Meeting Materials Webpage**
8/17/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
9/12/11	***SMMC Update** Public Meeting Region 11	Marathon	http://ahca.myflorida.com/medicaid/statewide_mc/pubinfomeetings.shtml
9/13/11	***SMMC Update** Public Meeting Region 11	Coral Gables	http://ahca.myflorida.com/medicaid/statewide_mc/pubinfomeetings.shtml
9/14/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
9/20/11	**Status of SMMC Program Submission** Presented to The Health Regulation Committee	Tallahassee	Presentation available upon request
9/21/2011	**Status of SMMC Program Submission** Presented to Health and Human Services Policy Committee	Tallahassee	Presentation available upon request
9/21/11	**Brief Update on Waiver Negotiations (Reform extension and SMMC)** Presented to Health and Human Services Appropriations Committee	Tallahassee	Presentation available upon request
9/27/11	**Florida Medicaid Program Overview** Presented to Greater Miami Chamber of Commerce	Miami	Presentation available upon request
10/3/11	***Medicaid Reform Technical Advisory Panel**	Teleconference	http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/Archive/2011.shtml
10/4/11	**Presentation to the House Health Care Appropriations Committee at the Florida House of Representatives**	Tallahassee	Presentation available upon request
10/25/11	***Medical Care Advisory Committee**	Tallahassee	http://ahca.myflorida.com/Medicaid/mcac/Archive/2011.shtml
10/26/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
11/18/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
11/29/11	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/Archive/2011.shtml
12/2/11	**SMMC Update** Presented to KidCare Coordinating Council	Tallahassee	Presentation available upon request

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

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

Legislative Activities and Public Workshops[7] 1115 Waiver Extension Request (June 10, 2011 – September 30, 2013)			
Date	**Meeting/Presentation**	**Location**	**Link to Meeting Materials Webpage**
1/16/13	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
1/22/13	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
1/23/13	**Florida Medicaid: An Overview** Presented to Senate Health Policy Committee	Tallahassee	http://ahca.myflorida.com/Medicaid/recent_presentations/SMMC_Status_Report_Senate_Health_Policy.pdf
1/28/13	***Low Income Pool Council**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/meetings.shtml
1/30/13	***Medicaid Reform Technical Advisory Panel**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/tap/meetings.shtml
1/31/13	***Enhanced Benefits Advisory Panel**	Tallahassee	http://ahca.myflorida.com/Medicaid/medicaid_reform/enhab_ben/meetings.shtml

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

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 19, 2013

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

Dear Ms. Whidden:

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

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

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

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

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

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

Visit AHCA online at AHCA.MyFlorida.com

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

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

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lam

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 19, 2013

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

Dear Ms. Osceola:

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

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

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

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

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

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

Sincerely,

/s/

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lam

Attachment I

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

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

Appendix A.4
Public Meeting Notices

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The Agency for Health Care Administration announces public meetings to which all persons are invited.
DATES AND TIMES: August 8, 2013, 1:00 p.m. − 5:00 p.m.; August 21, 2013, 10:00 a.m. − 4:00 p.m.; August 28, 2013, 10:00 a.m. − 4:00 p.m.
PLACE: August 8, 2013, 1:00 p.m. − 5:00 p.m.: Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1(877)415-3185, User ID#102 994 78
August 21, 2013, 10:00 a.m. − 4:00 p.m.: Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1(866)318-8612, User ID# 537 336 50
August 28, 2013, 10:00 a.m. − 4:00 p.m.: Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1(877)415-3182, User ID# 596 425 07

GENERAL SUBJECT MATTER TO BE CONSIDERED: PURPOSE: The purpose of the three LIP Council meetings is to discuss the LIP program including legislative updates, future federal funding and program design, funding methodology, policies and procedures in accordance with the Managed Medical Assistance Waiver (previously known as Medicaid Reform Waiver) as approved by the Centers for Medicare and Medicaid Services (Federal CMS) on June 14, 2013.

FUTURE OF LIP PROGRAM: The three LIP Council meetings are being held to discuss the future of the LIP program for the period July 1, 2014 through June 30, 2017. The state's 3-year waiver extension request including any proposed changes to the LIP program will be submitted to the Centers for Medicare and Medicaid Services in the fall of 2013.

DESCRIPTION OF DEMONSTRATION WAIVER: Florida's 1115 Research and Demonstration Waiver was initially approved by Federal CMS October 19, 2005. The Agency for Health Care Administration (Agency) implemented the demonstration July 1, 2006, in Broward and Duval Counties, and expanded to Baker, Clay, and Nassau Counties July 1, 2007. On December 15, 2011, Federal CMS approved to extend the demonstration through June 30, 2014.

On June 14, 2013, Federal CMS approved an amendment to the demonstration that allows for implementation of an improved model of managed care to all counties in Florida and the continuation of the LIP program. The amendment also changed the name of the demonstration to the Florida Managed Medical Assistance (MMA) program. The MMA program will be guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. The three fundamental elements of the program are:

- Risk-Adjusted Premiums will be developed for Medicaid enrollees in managed care plans. The risk-adjusted premium will minimize "adverse selection," and, provide an incentive for plans to take all necessary steps to identify Medicaid enrollees who have undiagnosed chronic conditions.
- Healthy Behaviors will be provided through the managed care plans to encourage and reward healthy behaviors.
- Low-Income Pool (LIP) will be maintained to provide direct payment and distributions to safety net providers in the state for the purpose of providing coverage to Medicaid, the uninsured and underinsured populations. Funds will be distributed to safety net providers that meet certain state and federal requirements.

A copy of the agenda may be obtained by contacting: Nicole Maldonado, (850)412-4287, Nicole.Maldonado@ahca.myflorida.com.

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 7 days before the workshop/meeting by contacting Nicole Maldonado, (850)412-4287, Nicole.Maldonado@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

For more information, you may contact: Nicole Maldonado, (850)412-4287, Nicole.Maldonado@ahca.myflorida.com.

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid

The Agency for Health Care Administration announces a public meeting to which all persons are invited.
DATE AND TIME: October 15, 2013; 1:00 p.m. – 4:00 p.m.
PLACE: Agency for Health Care Administration, Building 3, Conference Room C, 2727 Mahan Drive, Tallahassee, FL 32308. Those not able to attend in person may participate via conference phone by calling (888)670-3525 and entering the participant pass code 3715274100.

GENERAL SUBJECT MATTER TO BE CONSIDERED: The purpose of this public meeting is to discuss regular agenda topics and activities of the Medical Care Advisory Committee, and to provide stakeholders with the opportunity to provide meaningful comment on the progress of Florida's 1115 Managed Medical Assistance (MMA) Waiver (previously known as Medicaid Reform Waiver), approved by the Centers for Medicare and Medicaid Services (Federal CMS) on June 14, 2013. In addition, the future of Florida's 1115 MMA Waiver will be discussed to include the following topics: legislation creating the MMA program passed during the 2011 Florida Legislative Session, overview of the existing waiver and description of the draft waiver extension request. There will be an opportunity for public comment at the meeting.

As specified in Special Term and Condition #18, "Post Award Forum," of the 1115 MMA Waiver, the Agency for Health Care Administration (Agency) must afford the public with an opportunity to provide meaningful comment on the progress of the 1115 MMA Waiver within six months of approval of the waiver amendment (see "Summary Description of the Demonstration Waiver" below for more information), and annually thereafter. The Agency can use its Medical Care Advisory Committee to meet this requirement, and the Agency must publish the date, time and location of the public meeting at least 30 days prior to the public meeting date.

SUMMARY DESCRIPTION OF THE DEMONSTRATION WAIVER: Florida's 1115 Research and Demonstration Waiver was initially approved by Federal CMS October 19, 2005 to operate the demonstration for the period from July 1, 2006 to June 30, 2010. Implementation of the demonstration occurred in Broward and Duval Counties on July 1, 2006 with expansion to Baker, Clay and Nassau Counties occurring July 1, 2007. Federal CMS granted temporary extensions of demonstration until December 15, 2011, when final approval of the extension request was granted, for the period from December 16, 2011 to June 30, 2014.

On June 14, 2013, Federal CMS approved an amendment to the demonstration that allows for implementation of an improved model of managed care to all counties in Florida and the continuation of the Low Income Pool program. The amendment also changed the name of the demonstration to the Florida Managed Medical Assistance program. The program is guided by principles designed to improve coordination and patient care while fostering fiscal responsibility.

A copy of the agenda may be obtained by contacting: Ms. Carla Sims at (850)412-4013 or via email at Carla.Sims@ahca.myflorida.com.
For more information, you may contact: Ms. Carla Sims at (850)412-4013 or via email at Carla.Sims@ahca.myflorida.com.

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid

The Agency for Health Care Administration announces a public meeting to which all persons are invited.

DATES AND TIMES: October 8, 2013, 1:00p.m. – 3:30p.m.; October 9, 2013, 1:00p.m. – 3:30p.m.; October 11, 2013, 1:00p.m. – 3:30p.m.

PLACES: October 8, 2013, 1:00p.m. – 3:30p.m.: Egypt Shriners, 4050 Dana Shores Drive, Tampa, FL 33634. To participate by phone, please call 1(877)809-7263 and enter the participant passcode 72390513#.

October 9, 2013, 1:00p.m. – 3:30p.m.: Florida International University, Kovens Center, 3000 N.E. 151 Street, North Miami, FL 33181. To participate by phone, please call 1(877)299-4502 and enter the participant passcode 78073166#.

October 11, 2013, 1:00p.m. – 3:30p.m.: Agency for Health Care Administration, Building 3, 1st Floor, Conference Room A, 2727 Mahan Drive, Tallahassee, FL 32308. To participate by phone, please call 1(877)299-4502 and enter the participant passcode 88742870#. The public meeting in Tallahassee will also be available via webinar. To participate by webinar, follow the directions outlined below:

1) Go to https://suncom.webex.com/suncom/k2/j.php?ED=233333852&UID=1622458687&HMAC=56ac1e48ed9515d674af636a2a2b29b3c6d37a42&RT=MiMxMQ%3D%3D.

2) Enter your name and email address (or registration ID).

3) Click "Join".

4) Follow the instructions that appear on your screen.

GENERAL SUBJECT MATTER TO BE CONSIDERED: These public meetings are being held to solicit public input from recipients, providers and all stakeholders and interested parties on the development of the three-year extension request for Florida's 1115 Managed Medical Assistance (MMA) Waiver (previously known as Medicaid Reform Waiver), as approved by the Centers for Medicare and Medicaid Services (Federal CMS) on June 14, 2013. During the meetings, the following items will be discussed: the future of Florida's 1115 MMA Waiver, legislation creating the MMA program passed during the 2011 Florida Legislative Session, overview of the existing waiver and description of the draft waiver extension request. There will be an opportunity for public comment at the meetings.

SUMMARY DESCRIPTION OF THE WAIVER: Florida's 1115 Research and Demonstration Waiver was initially approved by Federal CMS October 19, 2005 to operate for the period from July 1, 2006 to June 30, 2010. Implementation of the waiver occurred in Broward and Duval Counties on July 1, 2006 with expansion to Baker, Clay and Nassau Counties occurring July 1, 2007. Federal CMS granted temporary extensions of the waiver until December 15, 2011, when final approval of the extension request was granted, for the period from December 16, 2011 to June 30, 2014.

On June 14, 2013, Federal CMS approved an amendment to the waiver that allows for implementation of an improved statewide model of managed care in 2014 and the continuation of the Low Income Pool program. The amendment also changed the name of the waiver to the Florida Managed Medical Assistance Waiver.

With the submission of the three-year waiver extension request, the state is seeking federal authority to extend Florida's MMA Waiver for the period July 1, 2014 to June 30, 2017. The waiver is designed to implement a new statewide managed care delivery system without increasing costs and to continue the Low Income Pool program. The program is guided by principles designed to improve coordination and patient care while fostering fiscal responsibility.

The MMA program will provide primary and acute medical care for the majority of Medicaid recipients through high quality, competitively selected managed care organizations. Moving from a fee-for-service system to the MMA program, the program increases consumer protections as well as quality of care and access for Floridians in many ways including:

• Increases recipient participation on Florida's Medical Care Advisory Committee and convenes smaller advisory committees to focus on key special needs populations;

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

• Ensures recipient complaints, grievances and appeals are reviewed immediately for resolution as part of the rapid cycle response system;

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

• Requires Florida's External Quality Review Organization to validate each plan's encounter data every three years;

• Enhances consumer report cards to ensure recipients have access to an understandable summary of quality, access, and timeliness regarding the performance of each participating managed care plan;

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

• Enhances metrics on plan quality and access to care to improve plan accountability; and

• Enhances the state's comprehensive continuous quality improvement strategy, focusing it on all aspects of quality improvement in Medicaid.

PUBLIC NOTICE AND PUBLIC COMMENT: OCTOBER 1, 2013 – OCTOBER 30, 2013

The Agency will conduct a 30-day public notice and comment period prior to the submission of the waiver extension request to Federal CMS. The Agency will consider all public comments received regarding the waiver extension request. The 30-day public notice and public comment period begins October 1, 2013 and ends October 30, 2013. To view a comprehensive description of the waiver extension request, please click the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/1115_Public_Notice_Document_Oct_1_2013.pdf

More information is available on the Agency's website at the following link:
http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA

To submit comments by postal service or internet e-mail, please follow the directions outlined below. When providing comments regarding the 1115 MMA Waiver extension request, please have '1115 MMA Waiver Extension Request' referenced in the subject line.

Mail comments and suggestions to:

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

You may also e-mail your comments and suggestions to: FLMedicaidWaivers@ahca.myflorida.com.

A copy of the agenda may be obtained by contacting: Ms. Linda Macdonald at (850)412-4031 or via email at Linda.Macdonald@ahca.myflorida.com.

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 7 days before the workshop/meeting by

contacting: Ms. Linda Macdonald at (850)412-4031 or via email at Linda.Macdonald@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

For more information, you may contact: Ms. Linda Macdonald at (850)412-4031 or via email at Linda.Macdonald@ahca.myflorida.com.

Appendix A.5
Emails to Interested Parties

Dear Interested Parties:

The Agency for Health Care Administration (Agency) will host a series of public meetings to solicit public input on the extension of Florida's 1115 Managed Medical Assistance (MMA) Waiver for the period July 1, 2014 to June 30, 2017. The waiver is designed to implement a new statewide managed care delivery system without increasing costs and to continue the Low Income Pool program. The MMA program will build upon the successful elements of the previous demonstration while incorporating stronger protections for consumers, as well as higher standards and more significant accountability measures for plans. The program will: Provide incentives to providers and recipients for efficient utilization of services by providing for coordination of health care in the most appropriate and cost-effective setting;

- Provide individuals a meaningful choice of plans and benefits; and
- Reduce fraud, abuse and waste through managed utilization of health care services.

During the meetings, the Agency will provide an overview of the provisions in Part IV of Chapter 409, Florida Statutes, related to the MMA program; an overview of the existing waiver including the June 14, 2013 federally approved waiver amendment; a description of the extension request; and time for public comments. *Please visit* http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA for more information on the public meetings, information on submitting comments, and to view a comprehensive description of the waiver extension request.

The MMA Waiver meetings will take place:

Tuesday, October 8, 2013 from 1:00 p.m. – 3:30 p.m.
Egypt Shriners
4050 Dana Shores Drive in Tampa
Conference Line: 1-877-809-7263
Participant Code: 723-905-13#

Wednesday, October 9, 2013 from 1:00 p.m. – 3:30 p.m.
Florida International University - Kovens Center
3000 N.E. 151 Street in North Miami
Conference Line: 1-877-299-4502
Participant Code: 780-731-66#

Friday, October 11, 2013 from 1:00 p.m. – 3:30 p.m.
Agency for Health Care Administration
2727 Mahan Drive Building 3, Conference Room A in Tallahassee
Conference Line: 1-877-299-4502
Participant Code: 887-428-70#

NOTE: *A video recording of the public meeting to be held in Tallahassee on October 11, 2013, will be posted on the Agency's website following the meeting.*

In addition to at the public meetings, comments can be submitted via mail or email. Comments will be accepted from October 1-October 30.

Mail comments and suggestions to:

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

E-mail comments and suggestions to: FLMedicaidWaivers@ahca.myflorida.com with "1115 MMA Waiver Extension Request" referenced in the subject line.

Additional information about the Statewide Medicaid Managed Care program can be accessed by visiting www.ahca.myflorida.com/SMMC. Specific information about the waiver extension and all federal authorities sought and granted can be viewed under the *Federal Authorities* tab.

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 45,000 health care facilities and 37 health maintenance organizations, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

Appendix A.6
Sample Letter to Florida Legislature

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 23, 2013

Representative Name
Adress
City, State, Zip

Dear Representative (Name):

As you may know, the Centers for Medicare and Medicaid Services (Federal CMS) initially approved Florida's 1115 Research and Demonstration Waiver on October 19, 2005 to operate for the period from July 1, 2006 to June 30, 2010. Implementation of the demonstration occurred in Broward and Duval Counties on July 1, 2006 with expansion to Baker, Clay and Nassau Counties occurring July 1, 2007. Federal CMS granted temporary extensions of the demonstration until December 15, 2011, when final approval of the extension request was granted, for the period from December 16, 2011 to June 30, 2014.

On June 14, 2013, Federal CMS approved an amendment that allows for implementation of the Managed Medical Assistance program, a component of the Statewide Medicaid Managed Care Program, in all counties in Florida and for the continuation of the Low Income Pool program. The amendment also changed the name of the demonstration to the Florida Managed Medical Assistance (MMA) waiver. The MMA program is guided by principles designed to improve coordination and patient care while fostering fiscal responsibility.

In accordance with Part IV of Chapter 409, Florida Statutes (F.S.), the Agency for Health Care Administration (Agency) is seeking federal authority to extend Florida's MMA Waiver for the period July 1, 2014 to June 30, 2017. As part of this process, the Agency is providing for a 30-day public notice and comment period prior to submitting the waiver extension request. *The 30-day public notice and public comment period begins October 1, 2013 and ends October 30, 2013.* Enclosed is a complete listing of public input meetings currently scheduled and additional information for submission of comments.

We welcome the participation of concerned citizens and lawmakers in an ongoing dialogue to help us achieve our mission of better health care for all Floridians. We look forward to your participation in this public process. If you have any questions, please feel free to contact Chris Chaney, Legislative Affairs Director, at 850-412-3612 or Chris.Chaney@ahca.myflorida.com.

Sincerely,

/s/

Justin M. Senior

Deputy Secretary for Medicaid

JMS/lam
Enclosure

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

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 7 days before the workshop/meeting by contacting Ms. Linda Macdonald at (850) 412-4031 or by email at Linda.Macdonald@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1 (800) 955-8771 (TDD) or 1 (800) 955-8770 (Voice).

The Agency will post on its website beginning October 1, 2013 through October 30, 2013, a comprehensive description of the waiver extension request, the approved Special Terms and Conditions of the waiver, waiver and expenditure authorities, and the Florida law (Part IV of Chapter 409, F.S.) that established the MMA program. The following is a link to the Agency's website: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA.

Comments will also be accepted by postal service or internet e-mail. The Agency's website provides the public the option of submitting written comments on the waiver extension request by mail or e-mail (see below). In addition, the Agency will provide attendees of the public meetings a comment card for the submission of written comments.

1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
FLMedicaidWaivers@ahca.myflorida.com

Appendix A.7
Media Alerts

FOR IMMEDIATE RELEASE
October 1, 2013

Contact: AHCA Communications Office
AHCACommunications@ahca.myflorida.com, 850-412-3623

MEDIA ADVISORY

Agency Welcomes Public Comment at Meetings about Managed Medical Assistance Waiver
-Public comment period runs October 1-October 30, 2013-

Tallahassee–The Agency for Health Care Administration (Agency) will host a series of public meetings to solicit public input about the extension of Florida's 1115 Managed Medical Assistance Waiver (MMA) for the period July 1, 2014 to June 30, 2017. The waiver is designed to implement a new statewide managed care delivery system without increasing costs and to continue the Low Income Pool program. The MMA program will build upon the successful elements of the previous demonstration while incorporating stronger protections for consumers, as well as higher standards and more significant accountability measures for plans.

During the meetings, the Agency will provide an overview of the provisions in Part IV of Chapter 409, Florida Statutes, related to the MMA program; an overview of the existing waiver including the June 14, 2013 federally approved waiver amendment; a description of the extension request; and time for public comments.

The MMA Waiver meetings will take place:

Tuesday, October 8, 2013 from 1:00 p.m. – 3:30 p.m.
Egypt Shriners
4050 Dana Shores Drive in Tampa
Conference Line: 1-877-809-7263
Participant Code: 723-905-13#

Wednesday, October 9, 2013 from 1:00 p.m. – 3:30 p.m.
Florida International University - Kovens Center
3000 N.E. 151 Street in North Miami
Conference Line: 1-877-299-4502
Participant Code: 780-731-66#

Friday, October 11, 2013 from 1:00 p.m. – 3:30 p.m.
Agency for Health Care Administration
2727 Mahan Drive Building 3, Conference Room A in Tallahassee
Conference Line: 1-877-299-4502
Participant Code: 887-428-70#

NOTE: *A video recording of the public meeting to be held in Tallahassee on October 11, 2013, will be posted on the Agency's website following the meeting.*

In addition to at the public meetings, comments can be submitted via mail or email. Comments will be accepted from October 1-October 30.

Mail comments and suggestions to:
1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
727 Mahan Drive, MS #8
Tallahassee, Florida 32308

E-mail comments and suggestions to: FLMedicaidWaivers@ahca.myflorida.com with "1115 MMA Waiver Extension Request" referenced in the subject line.

Additional information about the Statewide Medicaid Managed Care program can be accessed by visiting www.ahca.myflorida.com/SMMC. Specific information about the waiver extension and all federal authorities sought and granted can be viewed under the *Federal Authorities* tab.

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 45,000 health care facilities and 37 health maintenance organizations, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

# # #

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Appendix B
Number & Type of Plans Available Prior to Waiver

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

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

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

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

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

Appendix C Budget Neutrality Templates

HISTORICAL TREND CALCULATIONS

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

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

As of June 30, 2013

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

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

MMA Expansion Population (Mandatory and Voluntary)

* Data thru July 2013

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

** LTC costs have been excluded.

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

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

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

MMA AMENDMENT WITHOUT WAIVER (WOW) PROJECTION

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

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

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

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

Budget Neutrality Summary

Without-Waiver Total Expenditures

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

With-Waiver Total Expenditures

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

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

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

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

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

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

Appendix D
External Quality Review Reports

External Quality Review Reports Submitted by the waiver demonstration year

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

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

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

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

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

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

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

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

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

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

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

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

Annual Florida Medicaid Managed Care External Quality Review Technical Report

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Appendix E
Strategic HEDIS Analysis Report

Strategic HEDIS® Analysis Reports

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

July 1, 2007 through June 30, 2008

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

July 1, 2008 through June 30, 2009

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

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

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

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

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

Pediatric Care

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

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

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

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

Women's Care

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

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

Living With Illness

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

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

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

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

Use of Services

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

July 1, 2009 through June 30, 2010

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

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

Pediatric Care

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

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

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

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

Women's Care

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

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

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

Living With Illness

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

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

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

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

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

Access to Care

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

July 1, 2010 through June 30, 2011

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

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

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

Pediatric Care

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

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

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

Women's Care

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

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

Living With Illness

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

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

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

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

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

Use of Services

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

Access to Care

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

July 1, 2011 through June 30, 2012

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

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

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

Pediatric Care

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

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

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

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

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

Women's Care

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

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

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

Living With Illness

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

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

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

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

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

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

Use of Services

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

Access to Care

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

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Appendix F
Waiver and Expenditure Authorities

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

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

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

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

Title XIX Waivers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicaid Requirements Not Applicable to the Expenditure Authorities:

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

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

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

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

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

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

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

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State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

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

Mission Statement
Better Healthcare for All Floridians.