

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00206/4

TITLE: Florida Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

I. PREFACE

The following are the Special Terms and Conditions (STC) for the Florida Managed Medical Assistance Program (MMA) section 1115(a) demonstration (hereinafter “demonstration”) to enable Florida to operate the demonstration. The Centers for Medicare and Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act, and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. The parties to this agreement are the Agency for Health Care Administration (Florida) and 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 All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.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 July 31, 2014, and is approved through June 30, 2017.

The STCs have been arranged into the following subject areas:

- I. Preface;
- II. Program Description and Objectives;
- III. General Program Requirements;
- IV. Enrollment For the Managed Medical Assistance Program;
- V. Enrollment;
- VI. Benefit Packages and Plans in Managed Medical Assistance Program;
- VII. Cost-sharing;
- VIII. Florida Managed Medical Assistance Program Implementation;
- IX. Delivery Systems;
- X. Consumer Protections;
- XI. Choice Counseling;
- XII. Enhanced Benefits Account Program;
- XIII. Additional Programs;
- XIV. Low Income Pool;
- XV. Low Income Pool Participation Requirements and Deliverables;
- XVI. General Reporting Requirements;
- XVII. General Financial Requirements;
- XVIII. Monitoring Budget Neutrality;
- XIX. Evaluation of the Demonstration;
- XX. Measurement of Quality of Care and Access to Care Improvement; and,

XXI. Schedule of State Deliverables.

Attachment A: Quarterly Report Template

Attachment B: Historical PMPM and Trend Rates

Attachment C: MMA Implementation Plan

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 allowed the state to extend an improved model of managed care to all counties in Florida subject to approval of an implementation plan and a determination of readiness based on the elements of the approved plan. The amendment also changed the name of the demonstration to the Florida Managed Medical Assistance (MMA) program. CMS authorized implementation to begin no earlier than January 1, 2014, with the Medicaid Reform demonstration continuing to operate in the five Medicaid Reform counties until the MMA program was implemented there.

Under the June 2013 amended demonstration, most Medicaid eligibles were required to enroll in a managed care plan (either a capitated managed care plan or a fee-for-service (FFS) Provider Service Network (PSN) as a condition for receiving Medicaid. Enrollment was mandatory for Temporary Assistance for Needy Families (TANF)-related populations and the aged and disabled with some exceptions. The demonstration continued 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 Early and Periodic Screening, Diagnostic and Treatment; EPSDT). The demonstration provided 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 59. Beneficiaries in counties transitioning from Medicaid Reform to MMA continued to have access to their accrued credits under Enhanced Benefit Account Program (EBAP) for one year.

The June 2013 amended terms and conditions included 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, 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 (PIP) 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.

The approved 2014 extension of the demonstration continued the improvements authorized in the June 2013 amendment and extended all portions of this demonstration for three years, except for the Low Income Pool (LIP). CMS authorized extension of the Low Income Pool for one year, from July 1, 2014 through June 30, 2015.

- During the one-year extension for the LIP, expenditures were authorized to provide stability for providers, for a limited time during Florida's transition to statewide Medicaid managed care and a significantly reformed Medicaid payment system. Funding sources were limited only to existing state and local funding arrangements. The total amount of LIP funding could not exceed \$2,167,718,341 (total computable).
- Florida was required to analyze and develop a plan to reform Medicaid provider payments and funding mechanisms, with the goal of developing sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding. Expenditures authorized under the LIP were limited to uncompensated care costs of providers, the independent report discussed below, and other categories of expenditure as specified in the STCs.
- Uncompensated care costs were required to be verified through provider cost reports. CMS indicated that it would disallow unallowable payments to providers in prior demonstration years as identified on provider cost reports.

- During the one-year LIP extension, the state was required to use a portion of the LIP funds to commission a report from an independent entity on Medicaid provider payment in the state that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for these payments. The report was required to recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year (SFY) 2015-2016, to move toward Medicaid fee-for-service and managed care payments that ensure access for Medicaid beneficiaries to providers without payments through the LIP. The final report was due no later than March 1, 2015.

On June 30, 2015, pursuant to a letter to the state, CMS granted 60-days of interim expenditure authority under section 1115(a)(2) of the Social Security Act, to make federal funding available to Florida for interim LIP payments to providers from July 1, 2015 through August 31, 2015 of Demonstration Year (DY) 10, subject to a total spending limit of \$166.66 million for the combined federal and state shares of expenditures (with such amount being counted in determining the amount of any further extension of the Low Income Pool).

On October 15, 2015, CMS approved three amendments to the demonstration.

- The first amendment adds two populations as voluntary enrollees in managed care: Medicaid-eligible children receiving Prescribed Pediatric Extended Care (PPEC) services, and recipients residing in group home facilities licensed under section(s) 393.067 Florida Statutes (F.S.).
- The second amendment authorizes changes to managed care enrollment to auto-assign individuals into managed care during a plan choice period immediately after eligibility determination. The amendment also changes the auto-assignment criteria. Individuals will receive both their managed care plan assignment and information about choice of plans in their area. Individuals may actively select a plan during a 120-day change/disenrollment period post-enrollment.
- The third amendment authorizes expenditures under the LIP through June 30, 2017. The total amount of LIP funding in DY 10 (July 1, 2015 – June 30, 2016) will not exceed \$1 billion (total computable). The total amount of LIP funding in DY 11 (July 1, 2016 – June 30, 2017) will not exceed \$607,825,452 million (total computable). The changes represent a transition to a LIP that reflects the cost to providers of uncompensated care for uninsured individuals in the state, and that no longer pays for care that may be or has been provided through available coverage options. The changes set Florida on a path to administering a LIP in 2016-2017 (DY 11) that distributes funds based on the burden placed on providers by services for low-income, uninsured individuals for whom no other coverage options are, or could be, made available.

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

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate

of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.

- Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care by enrolling all Medicaid enrollees in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care).
- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low-income populations in the state by targeting LIP funding to reimburse uncompensated care costs for services provided to low-income uninsured patients at hospitals that are furnished through charity care programs that adhere to the Healthcare Financial Management Association (HFMA) principles.¹

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid Program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to this demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs as needed to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**

¹ <http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589>

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the federal law, regulation, or policy requires state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state will not be required to submit a Title XIX state plan amendment for changes to any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.
6. **Changes Subject to the Demonstration Amendment Process.** Changes related to demonstration features, such as, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost-sharing, evaluation design, LIP, 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 of Health and Human Services (“Secretary”) in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS of the amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7, below.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in these STCs, reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. CMS encourages the state to undertake a robust public process to ensure community engagement in the development and submission of amendments to the demonstration. Amendment requests must be accompanied by information that includes but is not limited to the following:
 - a. **Public Notice:** The state does not need to comply with the state public notice and comment process outlined in 42 CFR §431.408 until such time that CMS issues

- policy guidance to the contrary. However CMS encourages the state to comply with state public notice and comment process outlined in 42 CFR §431.408 in the event it seeks to amend the demonstration that modifies benefits, cost-sharing, eligibility, or delivery system changes. CMS will post and accept public comments on all amendments;
- b. Tribal Consultation: The state must provide documentation of the state's compliance with the tribal consultation requirements outlined in STC 15 for demonstration amendments. Such documentation shall include a summary of the tribal comments and identification of proposal adjustments made to the amendment request due to the tribal input;
 - c. Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including; what the state intends to demonstrate via the amendment as well as impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI state plan amendment, if necessary;
 - d. 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 for the amendment;
 - e. A data analysis worksheet 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;
 - f. An up-to-date CHIP allotment neutrality worksheet, if necessary; and
 - g. Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. 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 transition and phase-out plan consistent with the requirements of paragraph 9.

- b. Compliance with Transparency Requirements at 42 CFR §431.412: As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

9. Demonstration Transition and 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 transition and 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 transition and phase-out plan to CMS, the state must publish on its website the draft transition and 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.
- b. 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.
- c. Transition and 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 (including those on any applicable wait lists), 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 those beneficiaries whether currently enrolled or on a wait list, determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.
- d. 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.
- e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g): CMS may

expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR § 431.416(g).

- f. 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 enrollees.

10. 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 enrollees.

11. 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.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.
13. **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 enrollees.
14. **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.
15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the state public notice process for Section 1115 demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.
 - a. In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).
 - b. 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 demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** No federal matching for administrative or service expenditures for this demonstration will take effect until the approval date identified in the demonstration approval letter.
17. **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 83, 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 84.
18. **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 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. MLR requirements are to be reported by the capitated plans on a calendar year basis, with quarterly unaudited financial reports submitted within forty-five (45) calendar days after each quarter ends. An annual audited financial report shall be submitted by August 1st of each year for the previous calendar year, allowing for three months of claims run out. The MLR shall take into consideration any payment of the Achieved Savings Rebate required under Chapter 409.967(3), F.S., the calculation of which closely follows federal MLR guidance. Examples of possible state actions include, but are not limited to, lowering the capitation rate; audits to make sure services are being provided in accordance with plan contract; enforcing corrective action for poor reporting; risk adjustment to rates; and plan termination. CMS will determine if the state will be required to take additional corrective action with the capitated managed care plans or PSN for the reported MLR variances.

The state shall monitor each plan's financial solvency, appropriateness of capitation rates, and provision of Medicaid services. The state shall submit to CMS quarterly and annual MLR reports with notation of concerns and actions taken by the state for each managed care plan or PSN that is above a MLR of 95 percent or below 75 percent.

- i. For plans above a 95 percent MLR, the state shall report any concerns about the plans' financial viability, plan performance, and continuation with the MMA program.
 - ii. For plans below a 75 percent MLR, the state shall report any concerns with beneficiary access to care and utilization, capitation rates, or MCO reporting.
- 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.

IV. ENROLLMENT FOR 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.

20. **Enrollment in managed care under the MMA program.** The MMA program began implementation on April 1, 2014 and is expected to complete implementation in all counties by September 30, 2014. MMA program enrollees are individuals eligible under the approved state plan, who reside in the MMA program regions and who are described below as “mandatory enrollees” or as “voluntary enrollees”. Mandatory enrollees are required to enroll in a capitated managed care plan or FFS PSN as a condition of receipt of Medicaid benefits. Voluntary enrollees 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 Managed Care Enrollees – 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 enrollees.

Mandatory Managed Care Enrollees			
Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Infants under age 1 Population 2	No more than 206% of the Federal Poverty Level (FPL).	Title XIX	TANF & related grp
Children 1-5 Population 2	No more than 140% of the FPL.	Title XIX	TANF & related grp
Children 6-18 Population 2	No more than 133% of the FPL.	Title XIX	TANF & related grp
Blind/Disabled Children Population 1	Children eligible under Supplemental Security Income (SSI), or deemed to be receiving SSI.	Title XIX	Aged/Disabled
IV-E Foster Care and Adoption Subsidy Population 2	Children for whom IV-E foster care maintenance payments or adoption subsidy payments are received – no Medicaid income limit.	Title XIX	TANF & related grp
Pregnant women Population 2	Income not exceeding 191% of FPL.	Title XIX	TANF & related grp
Section 1931 parents or other caretaker relatives Population 2	No more than Aid to Families with Dependent Children (AFDC) Income Level (Families whose income is no more than about 31% of the FPL or \$486 per month for a family of 3.)	Title XIX	TANF & related grp
Aged/Disabled Adults Population 1	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA).	Title XIX	Aged/Disabled

Mandatory Managed Care Enrollees			
Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Former foster care children up to age 26	Individuals who are under age 26 and who were in foster care and receiving Medicaid when they aged out.	Title XIX	TANF & related grp
Optional State Plan Groups			
State-funded Foster Care or Adoption assistance under age 18 Population 2	Who receive a state Foster Care or adoption subsidy, not under title IV-E.	Title XIX	TANF & related grp
Individuals eligible under a hospice-related eligibility group Population 1	Up to 300% of SSI limit. Income of up to \$2,130 for an individual and \$4,260 for an eligible couple.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236 Population 1	This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category in paragraph (c).	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community-based waiver group specified at 42 CFR 435.217 Population 1	This group includes institutionalized individuals eligible under this special HCBS waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category in paragraph (c).	Title XIX	Aged/Disabled

- b. Medicare-Medicaid Eligible Participants – Individuals fully eligible for both Medicare and Medicaid are required to enroll in an MMA plan 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 22.
- c. Voluntary enrollees – The following individuals are excluded from mandatory enrollees under subparagraph (a) but may choose to be voluntary participants in an MMA plan:
- i. Individuals who have other creditable health care coverage, excluding Medicare;
 - ii. Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;

- iii. Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF-IID);
 - iv. Individuals with developmental disabilities enrolled in the home and community-based waiver pursuant to state law, and Medicaid recipients waiting for waiver services;
 - v. Children receiving services in a PPEC facility; and
 - vi. Medicaid-eligible recipients residing in group home facilities licensed under section(s) 393.067 F.S.
- d. Excluded from MMA Program Participation - The following groups of Medicaid eligibles are excluded from enrollment in managed care plans under 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. Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law. (These individuals are inmates not eligible for covered services under the state plan, except as inpatients in a medical institution).

V. ENROLLMENT

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

21. **New Enrollees.** At the time of their application for Medicaid, individuals who would be mandated to enroll in managed care under MMA 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, and to indicate a plan choice selection if they are prepared to do so. Eligible individuals will be enrolled in a managed care plan upon eligibility determination. If the individual has not selected a plan at the time of the approval of eligibility, the state may auto-assign the individual into a managed care plan. Individuals who have been auto-assigned at enrollment will receive both their managed care plan assignment and information about choice of plans in their area. Such individuals then may actively select a plan during a 120-day change/disenrollment-period without cause post-enrollment. All individuals will be provided with information regarding their rights to change plans.

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.

In accordance with STCs 2 and 3, the state must ensure that the enrollment and other managed care practices are brought into compliance with future final CMS Medicaid managed care regulations within the timeframe to be specified in that final rule (see as reference, proposed rule at 80 FR 104, June 1, 2015).

22. Auto-Enrollment Criteria. Each enrollee must have an opportunity to select a managed care plan before or upon being determined eligible for Medicaid. Individuals must be provided information to encourage an active selection electronically or in print. Enrollees who fail to choose a plan by the time their eligibility is determined 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. Whether the plan has sufficient provider network capacity, including dental network capacity, to meet the needs of the enrollee;
- b. Whether the recipient has previously received services from one of the plan's primary care providers;
- c. Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

23. 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 subparagraphs 22(a) - (c) 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 120 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.

24. **Lock-In/Disenrollment.** Once a mandatory enrollee has selected or been assigned an MMA plan, the enrollee shall be enrolled for a total of 12 months, until the next open enrollment period, unless the individual is determined ineligible for Medicaid. The 12 month period includes a 120-day period upon initial eligibility or re-eligibility determination to change or voluntarily disenroll from a plan without cause and select another plan. If an individual chooses to remain in a plan past 120 days, the individual will be permitted no further changes in enrollment until the next open enrollment period, except for cause. Good cause reasons for disenrollment from a plan are defined in Rule 59-G-8.600, Florida Administrative Code. 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.

25. **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 individual will have the same change/disenrollment period without cause as upon initial enrollment.

VI. BENEFIT PACKAGES AND PLANS IN THE MMA PROGRAM

26. **Customized Benefit Packages.** MMA plans 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 paragraphs 26-32. For other plans, 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.

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, 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.

27. **Overall Standards for Customized Benefit Packages.** All benefit packages must be prior-approved by the state and CMS 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. Customized benefit packages, as analyzed through the Plan Evaluation Tool (PET) discussed below, must be submitted to CMS for approval as part of the standard CMS contract review process.
28. **Plan Evaluation Tool.** The state will utilize a PET to determine if a plan that is applying for, or has been awarded, an MMA plan contract meets state requirements. The PET measures for actuarial equivalency and sufficiency. Specifically, the PET: (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.
29. **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.

30. **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.
31. **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.

VII. COST-SHARING

32. **Premiums and Co-Payments.** The state must pre-approve all cost-sharing allowed by 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.

VIII. MANAGED MEDICAID ASSISTANCE (MMA) PROGRAM IMPLEMENTATION

33. **MMA Program Implementation Requirements.** The state will continue with the implementation of the MMA program in a region if it meets the following implementation requirements for that region (subject to CMS review and approval).
- a. **Implementation Schedule:** The approved implementation schedule and plan for MMA are included as Attachment C of these STCs. The plan includes the following:
- 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.
- 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 (LTSS).
 - 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 not 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 18, 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 18 of these special terms and conditions and EPSDT requirements described in paragraph 26 of these STCs.
 - g. Prior to implementation in each region, the state must submit a report to CMS on its compliance with subparagraphs (c) 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).

34. **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 33. Note: Medicare-Medicaid eligible beneficiaries who are enrolled in a

Medicare Advantage plan will participate in an open enrollment period that coincides with the Medicare open enrollment period (October 15 through December 7) to facilitate beneficiaries' choice of Medicare and Medicaid managed care plans. Therefore, MMA coverage will begin on January 1, 2015 for beneficiaries in both Medicare and Medicaid managed care plans. 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

IX. DELIVERY SYSTEMS

35. **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 (MCO) – An entity (such as Health Maintenance Organization, Accountable Care Organization, capitated Provider Service Network, or Exclusive Provider Organization) that meets the definition of 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 F.S. 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 of 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.

36. 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 to 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 42 C.F.R. §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 38. 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.

Should the state undergo another Medicaid managed care procurement for MMA plans during the demonstration period, the state must submit a report to CMS no later than 30 days after the selection of new MMA plans 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 LTSS 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.

37. Freedom of Choice. An enrollee's freedom of choice is limited to the providers through whom enrollees may seek services. 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 Long-term Care (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.

38. Specialty Plans. Specialty plans may participate in the MMA program.

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 such as: (1) plans that primarily serve children with chronic conditions; or (2) 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 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 CMS.

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.

39. 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.

40. Requirements for Special Populations.

a. HIV Specialty Plans

- i. The state will auto-enroll Medicaid beneficiaries identified with a diagnosis of HIV or AIDS to a specialty plan, where available if the beneficiary does not select an MMA plan. These beneficiaries may be identified with a combination of diagnosis codes on 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 or the beneficiary will be auto-assigned to a specialty plan, if available, in his or her region. The notification will provide the beneficiary with information regarding the benefits of enrolling in a specialty plan, the enrollee will have 120-day period following enrollment to change plans or disenroll 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 the first year of the MMA Program.
- ii. The Foster Care child's legal guardian may enroll the child in an MMA 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 plan, the state may enroll the foster care child into the Children's Specialty Plan available in the region.

X. CONSUMER PROTECTIONS

41. **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 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 110.

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 LTSS; 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 (SUD) 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 110. In addition, each advisory committee must provide input to the state on the consumer report cards, set forth in STC 107.

42. **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.
43. **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.
44. **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.
45. **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.
46. **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.
47. **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.

48. **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 120th day following their enrollment, that they will not be able to continue with the treating provider and provide the option to either:
 - A. Continue services with a network provider; or,
 - B. Disenroll for cause.

49. **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.

50. **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.
51. **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.
52. **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 82.
53. **State Review of Beneficiary Complaints, Grievances, and Appeals.** During the initial implementation of the 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 83. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

XI. CHOICE COUNSELING

54. **Choice Counseling Defined.** The state shall contract for choice counselor services in 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.

55. **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.
56. **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.
57. **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.
58. **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 (AHCA) website or by phone. The state or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees. The state must ensure mechanisms are in place to monitor and evaluate choice counseling call center metrics and the individual performance of choice counseling personnel.

XII. HEALTHY BEHAVIORS PROGRAM UNDER THE MMA PROGRAM

59. **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, an alcohol or substance abuse treatment program 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.

XIII. ADDITIONAL PROGRAMS

63. **Transition of two 1915(b)(3) programs and one state plan program.** On January 1, 2014 programs previously authorized under Florida’s Section 1915(b) Medicaid Managed Care Waiver, expired and instead became authorized under this demonstration. These programs will be available in all parts of the state.
- a. The Healthy Start Program - previously 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) – previously authorized as 1915(b)(3) services under Florida’s Section 1915(b) Medicaid Managed Care Waiver; and
 - c. The Comprehensive Hemophilia Program previously authorized as state plan covered service under Florida’s Section 1915(b) Medicaid Managed Care Waiver.
64. **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, and 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.

65. 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.

66. 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), Stimat (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.

XIV. LOW INCOME POOL

67. **Low Income Pool Definition.** In Demonstration Year 10, the LIP provides transitional government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. In Demonstration Year 11 (SFY 2016-2017) the LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals that are uninsured. Uncompensated care includes charity care for the uninsured but does not include uncompensated care for insured individuals, “bad debt,” or Medicaid and CHIP shortfall. The definition also excludes the estimated impact on uncompensated care that would result from Medicaid expansion, or that has resulted from Marketplace coverage, under the Affordable Care Act. This is reflected in the total computable dollar limit discussed in STC 68.
68. **Availability of Low Income Pool Funds.** The following paragraph presents the total computable dollar limit for LIP spending in DYs 10 and 11, subject to assurances.
- a. **Total LIP Amount.** The total computable dollar limit for LIP expenditures in DY 10 will be \$1 billion. The total computable dollar limit for LIP expenditures in DY 11 will be \$607,825,452 million.
 - b. **Assurance.** As reflected in the LIP participation requirements in STC 77, in DY 11, the state and participating providers who plan to participate in LIP for DY11 will provide assurance that LIP claims include only costs associated with uncompensated care that is furnished through a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association operated by the provider.

69. **Capped Annual Allotments.** All annual LIP funds must be expended by July 31 following each authorized demonstration year. Any amount not expended does not roll over. Capped annual allotment amounts that are not distributed because of penalties, recoupment due to payments exceeding uncompensated care cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the state and not recoverable.
70. **LIP Reimbursement and Funding Methodology.** The Reimbursement and Funding Methodology Document (RFMD) is prepared by the state and documents LIP permissible expenditures, including the non-federal share and the total computable expenditures. The RFMD provides that total computable LIP payments to providers for uncompensated care costs must be supported by uncompensated care costs incurred and reported by providers as charity care on the provider's financial records. Through the RFMD, the state must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for uncompensated care as charity care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the demonstration year.
- a. Prior to November 30, 2015, the state must submit a draft of DYs 10 and 11 (2016-2017) RFMDs to CMS for approval and CMS will work with Florida towards approval by January 31, 2016. However, Florida may not claim federal financial participation for LIP payments in DY 11 until after a revised RFMD is approved by CMS.
 - b. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not exceed allowed uncompensated care costs, using the CMS approved RFMD cost review protocol. The state must submit a LIP Cost Reconciliation report to CMS within two years after the end of each DY showing cost reconciliation results by provider. CMS will review the state's reconciliation and share any findings with the state. To the extent that payments are found to exceed allowed uncompensated care costs, the federal portion of any excess payment must be returned to CMS by submitting a decreasing expenditure adjustment (Line 10B). If the state has not submitted its LIP Cost Reconciliation Report for a DY within the timeframe described above, CMS may issue a deferral or disallowance for an amount not to exceed the total of the state's submitted LIP expenditures for that DY.
 - c. A provider may at any time during a demonstration year disclose to the state that LIP payments to that provider exceeded allowed uncompensated care costs. The state must report that overpayment on the CMS-64 by submitting a decreasing expenditure adjustment (Line 10B) by the next quarter and no later than one year from the date of disclosure.

- d. Payments from LIP to hospitals are to be considered Medicaid hospital revenue for the purpose of determining the hospital-specific DSH limits defined in section 1923(g) of the Act.
- e. For the purposes of this paragraph, allowed uncompensated care cost follows the definitions described in paragraph 71.

71. 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.

- a. In DY 10 (SFY 2015-2016), these health care costs may be incurred by the state, or by hospitals, clinics, or by other provider types to furnish medical care for Medicaid, uninsured and underinsured populations 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).
- b. In Demonstration Year 11 (SFY 2016-2017), these health care costs may be incurred by the state or by providers to furnish uncompensated medical care as charity care for low-income individuals that are uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the Healthcare Financial Management Association.
 - i. Providers may be categorized in up to two groups: hospitals and Medical School Physician Practices. Each group may be divided into up to four tiered subgroups, based on subdividing a list of the providers ranked by their amount of uncompensated charity care cost or charges (defined as in (b) above) as a percentage of their privately insured patient care cost or charges—that ratio is the sole basis on which tiered groups may be defined.
 - ii. All providers in either group that meet LIP provider participation requirements and that furnished uncompensated charity care must receive some amount of payment with the amounts paid being proportional to the ratio defined in (i) above (i.e. subgroup members that provide greater proportions of uncompensated charity care will fall into tiers with higher percentages of uncompensated care payments).
 - iii. All providers that must receive some amount of payment (following (ii) above) must be paid the same percentage of their charity care cost within each group (or within each tiered subgroup).

- iv. Determination of (i) through (iii) may be effectuated using contemporaneous uncompensated care data, or equivalent data from a prior year not more than three years prior to the DY.

72. Low Income Pool Permissible Expenditures 10 percent Sub Cap. For DY 10, up to \$100 million 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. Hospital costs funded by these payments cannot be included as allowable costs for purposes of any federally-supported program. 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 70.

73. Low Income Pool Permissible Hospital Expenditures. Hospital cost expenditures from the LIP will be paid up to 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.

74. Low Income Pool Permissible Non-Hospital Based Expenditures. To ensure services are paid up to or at cost, the Reimbursement and Funding Methodology document defines the cost reporting strategies required to support non-hospital based LIP expenditures.

75. 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.

XV. LOW INCOME POOL PROVIDER PARTICIPATION REQUIREMENTS AND DELIVERABLES

76. Aggregate LIP Funding. In DY 10, up to \$1 billion in LIP funds will be available to the state and in DY 11, up to \$607,825,452 million in LIP funds will be available to the state. This amount will be limited by any penalties that are assessed by CMS pursuant to STC 78 and/or reconciliation overpayments as discussed in STC 70. Provider Participation requirements, described in STC 77 must be met for the state and facilities to have access to 100 percent of the annual LIP funds.

77. LIP Provider Participation Requirements. Hospitals and Medical School Physician Practices who receive LIP funds have certain participation requirements. If they do not meet the participation requirements, they cannot receive LIP funds. The state may grant an exemption to a hospital of the requirement in (a)(ii) upon finding that the hospital has

demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan. A letter of denial, or some other comparable evidence, will be required to make such a finding.

a. **Hospitals.**

- i. Must contract with at least fifty percent of the Standard Plan Managed Care Organizations (MCOs) in their corresponding region;
- ii. Must contract with at least one Specialty Plan serving each specialty population in their corresponding region; and,
- iii. Participate in the Florida Event Notification program.
- iv. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care furnished through the a charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that adheres to the principles of the Healthcare Financial Management Association and is operated by the provider. Such a charity care program must be established prior to the end of DY 10.
- v. In DY 11 for administrative purposes, participating hospitals must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization based on the ratio of Medicaid days to total patient days reported on the most recent accepted Florida Hospital Uniform Reporting System (FHURS) data.

b. **Medical School Physician Practices**

- i. Must participate in the Florida Medical School Quality Network,
- ii. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care through the provider's charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that meets the principles of the Healthcare Financial Management Association. Such a charity care program must be established prior to the end of DY 10.
- iii. In DY 11, participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization

78. Deliverable Requirements. CMS will reduce available LIP federal funding on an annual basis for the state's failure to meet deliverable requirements. A reduction in available LIP federal funding of \$6 million will be assessed annually for each deliverable requirement that is not met. The annual penalty applies to the demonstration year in which the deliverable is due, even if the deliverable itself pertains to a different

demonstration year. LIP federal dollars that are lost as a result of deliverable requirements not being met, are surrendered by the state through a CMS-64 adjustment (Summary Line 9D Other). Deliverable requirements include but are not limited to the following:

- a. Timely submission of an annual estimate and annual final uncompensated care report. Submission by June 1 of each year, detailing for the upcoming demonstration year, the projected LIP providers, the estimated per provider of uncompensated care to be furnished through charity care, and the IGTs associated with each provider. Submission by October 1 of each year, for the demonstration year just ended, the final report of the LIP providers, uncompensated care claimed through charity care and the final IGTs. Both the estimate and final report must also be posted on the state Medicaid website.
- 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.
- c. Timely submission of all demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.
- d. 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.

XVI. GENERAL REPORTING REQUIREMENTS

79. **General Financial Requirements.** The state must comply with all general financial requirements set forth in Section XVII.
80. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XVIII. The state must submit any corrected budget neutrality data upon request.
81. **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.

82. **Monitoring Calls.**

- a. 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.
- b. 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.

83. **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 87(c)(ii), 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 with notation of concerns and actions taken by the state for each managed care plan or PSN that is above a MLR of 95 percent or below 75 percent, as described in 18(c);
- 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 MMA Program counties including the number of beneficiaries who made an affirmative choice to change plans after being auto-enrolled into a plan; problems related to changing plans or disenrollment; data on the reasons for changing plans; and the number of beneficiaries that made an affirmative plan choice during the enrollment window, and then later decided to change plans, including the data on the reason for changing plans. Data must be presented separately by plan, including Specialty Plans.
- h. Efforts to promote alignment and integration with Medicare for Medicare-Medicaid eligible individuals, including the number of enrollees 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.
84. **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 83 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 110, 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.

85. **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 83. On June 24, 2012, the state notified CMS that a transition was not applicable to the demonstration.

XVII. GENERAL FINANCIAL REQUIREMENTS

86. **Quarterly Expenditure Reports: CMS 64.** 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.

87. Reporting Expenditures Under the Demonstration: CMS-64. 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 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. The state will work with CMS to develop a method of reporting 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, as instructed in the State Medicaid Manual. 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, reporting expenditures for the demonstration populations by eligibility group. Payments made to provide health care services to the eligibility groups listed below are expenditures subject to the budget neutrality

limit. The waiver names designate the waiver forms in the MBES/CBES system to report Title XIX expenditures associated with the demonstration.

- i. The CMS-64 will reflect the expenditures for statewide MMA populations, including those attributable to MMA mandatory and voluntary populations. The following names and definitions will be utilized for the CMS-64 reporting purposes:
 - (A) MEG 1: Demonstration Population 1 – (Aged/Disabled): Aged and disabled demonstration enrollees. Waiver Name: Aged/Disabled
 - (B) MEG 2: Demonstration Population 2 – (TANF & related grp): TANF demonstration enrollees. Waiver Name: TANF & related grp
 - (C) MEG 3: Low Income Pool
 - ii. **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.
- e. Excluded Services. The following services are excluded from the demonstration:
- i. Home and Community Based Service Waiver Services (Adult Cystic Fibrosis, Model Waiver ((formerly Katie Beckett Model Waiver Services)), Project AIDS Care, Familial Dysautonomia, Development Disabilities Individual Budgeting, Traumatic Brain Injury and Spinal Cord Injury);
 - ii. Long Term Care Waiver;
 - iii. ICF/IID Institutional Services;
 - iv. School Based Administrative Claiming;
 - v. Nursing facility services for children under age 18;
 - vi. Nursing facility services for recipients age 18 and older in MMA, except for nursing facility services used as a downward substitution service for inpatient services;
 - vii. Medical foster care services;
 - viii. Prescribed pediatric extended care (PPEC) services;
 - ix. County matching programs (Substance Abuse and Medicaid Certified School Match Services);
 - x. Redirections Services;
 - xi. State Mental Health Hospital services for recipients age 65 and older;
 - xii. Certain physician-injectable procedures;
 - xiii. Vaccines for Children program for MediKids; and
 - xiv. Early Intervention Services.
- 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 (at its option) exclude from the budget neutrality test for this demonstration the portion of the increase for which the federal government pays 100 percent. Should the state elect this, these amounts must be reported on the base forms CMS-64.9 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. 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 with the waiver name "ADM".
- 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.
- j. Expenditures Subject to the Budget Neutrality Limits. The following types of expenditures are subject to the budget neutrality limits for this demonstration.
 - i. All medical assistance expenditures for Medicaid beneficiaries in the categories listed in paragraph 20(a), (b), or (c) (regardless of their managed care enrollment status), other than expenditures for services listed in paragraph 92(d),
 - ii. All expenditures made under section 1115(a)(2) expenditure authority, including all payments made under LIP, through June 30, 2017.

88. 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 83, the actual number of eligible member months for the three MEGs described in paragraph 99 the state must provide CMS, upon request, eligible member months by population as defined in paragraph 87(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.

89. 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 will 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.

90. 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 MMA 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,

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.

91. Sources of Non-Federal Share. The state certifies that the matching non-federal share of funds for the demonstration are state/local monies, and that local funding is derived from state or local tax revenues. The state further certifies that such funds shall not be used as the non-federal share for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with Title XIX 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.

92. 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.

93. **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.

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

95. **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.

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 96 and 97 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 87. Federal financial payments for the MMA 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.

96. **Budget Neutrality Limit for the LIP.** The LIP amount is capped at \$1 billion total computable for DY 10 and \$607,825,452 million for DY 11. Funds not distributed in a DY may be rolled over to the next DY. The federal share of the 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.

97. **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 87 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.
98. **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.
99. **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 87(d):
 - a. MEG 1: Aged/Disabled
 - b. MEG 2: TANF & related grp
 - 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 Aged/Disabled 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 MMA service expenditures will be the cost projections for the Aged/Disabled 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 88.

- b. Projected PMPM Cost - The PMPM costs for each MEG used to calculate the annual budget neutrality expenditure limit for this demonstration is specified below.

Demonstration Year	Aged/Disabled MEG	Trend Rate	TANF & rel grp MEG	Trend Rate
DY 9 (SFY 2015)	\$786.70	4.1%	\$324.13	4.6%
DY 10 (SFY 2016)	\$ 830.22	4.1%	\$339.04	4.6%
DY 11 (SFY 2017)	\$ 864.26	4.1%	\$354.64	4.6%

100. **How the Limit will be Applied.** The limits as defined in paragraphs 96 through 99 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.
101. **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.
102. **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 84. This amount will be compared with the actual FFP claimed by the state under budget neutrality. Using the schedule below as a guide for the PCCM budget limit, if the state exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The state will subsequently implement the approved program.

<u>Year</u>	<u>Cumulative target definition</u>	<u>Percentage</u>
Year 9	Years 1 through 9 combined budget neutrality cap plus	1 percent
Year 10	Years 1 through 10 combined budget neutrality cap plus	0.5 percent

XIX. EVALUATION OF THE DEMONSTRATION

103. **Submission of Draft Evaluation Design Updates.** Included with any application for an amendment or an extension, the state must submit to CMS for approval a draft evaluation design update that revises the evaluation design in relation to the proposed changes to the demonstration and that builds upon the most recent evaluation findings. 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 105). 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 105(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.

104. **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
105. **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.

- 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 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. (This Domain will sunset after DY 10). Beginning DY11, the impact of LIP funding on hospital charity care programs;
 - vi. The impact of LIP funding on per-capita costs for uninsured populations for DY 11;
 - vii. 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;
 - viii. 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;
 - ix. The effect of transitioning the EBAP program from direct state operation to the MMA plans' Healthy Behaviors programs; and,
 - x. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals.
 - xi. The effectiveness of the Express Enrollment process in connecting beneficiaries with care in a timely manner; and
 - xii. The benefits and outcomes associated with participation in the Event Notification Service.
- 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 include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.
105. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design and the draft MMA evaluation strategy as part of the amendment or extension approval process. The approved evaluation design and strategy will be part of the amendment or extension approval documents. 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 within 120 days of the end of each renewal period. The state must submit the final evaluation report within 60 days after receipt of CMS' comments.

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.

XX. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE IMPROVEMENT

106. **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 annual validation of encounter data for all MCOs and PIHPs.

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)].

107. **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.

108. **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:
 - i. Population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that have been identified as in need of improvement;
 - ii. Integrating primary care and behavioral health; and
 - iii. Reducing preventable readmissions.

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.

109. **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.

110. 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 the MMA program, and managed LTSS. 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. The currently approved Florida CQS may be found at http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml.

- 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 103. 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 103, 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 state must revise (and submit to CMS for review and approval) their CQS whenever the MMA demonstration is renewed or materially amended or 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 or renewal.

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 41, 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 84, 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. If the state chooses to exercise the non-duplication option in 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).

XXI. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
60 days following the end of the quarter	Quarterly Progress Reports	Section XVI, STC 83
120 days following the end of the demonstration year	Annual Report	Section XVI, STC 84
30 days following the end of the quarter	Quarterly Expenditure Reports	Section XVII, STC 86
90 days following the award of the demonstration	Managed Care Policies	Section III, STC 18 (a), (b), (d), and (e)
October 31, 2013	MMA Program Implementation Schedule	Section VIII, STC 33(a) and Attachment D
30 days in advance of implementation in each region	Implementation regional reports	Section VIII, STC 33f
7 months following the end of each quarter	Quarterly Medical Loss Ratio Reporting by the capitated plans for Demonstration Counties	Section III, STC 18 (c)
30 days following award of the demonstration	Premium Assistance Transition Plan	Section XVI, STC 85
July 1, 2012	ACA Transition Plan	Section XVI, STC 85
November 30, 2015	LIP draft RFMD for DYs 10 and 11	Section XIV, STC 70
Within 2 years of the end of each DY	LIP Cost Reconciliation Report	Section XIV, STC 70

June 1, annually	LIP Provider UC and IGT estimate report	Section XV, STC 78(a)
October 1, annually	LIP Provider, UC and IGT final report	Section XV, STC 78(a)
Within applications for amendments and extensions	Draft Evaluation Design	Section XIX, STC 103
120 days following the award of the MMA amendment	Draft Comprehensive Quality Strategy	Section XX, STC 110

ATTACHMENT A

Under paragraph 83, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework showing the broad categories of information to be reported and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include all items described in paragraph 90 and an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – Florida Managed Medical Assistance Program

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

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

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

Introduction

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

Enrollment Information

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

Demonstration Populations (as hard coded in the Form CMS-64)	Total as of end of Current Quarter	Voluntary Disenrolled in Current Quarter	Involuntary Disenrolled in Current Quarter
Population 1 - Aged/Disabled			
Population 2 - TANF & related grp			
After January 1, 2014, expenditures for statewide MMA populations, including those attributable to MMA voluntary populations are to be included in this reporting.			

Outreach/Innovative Activities

Summarize outreach activities including but not limited to Choice Counseling, MMA implementation outreach and educational tour and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to: approval and contracting with new plans; benefit changes; legislative activity; Healthy Behaviors program benefits by health plan and participation rates; network adequacy including customer service reporting; complaints, grievances and appeals; reporting on managed care plans critical incidents, efforts to promote alignment or integration for Medicare-Medicaid eligible individuals.

Consumer Issues

Provide a summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Identify and address any appeals related to medical necessity under the EPSDT benefit.

Quality Assurance /Monitoring Activities

Identify any quality assurance/monitoring activity in the current quarter, including but not limited to MCAC recommendations, PIP progress and Consumer Health Plan Report Cards.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Financial/Budget Neutrality Development/Issues

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

Enclosures/Attachments

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

State Contact(s)

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

Date Submitted to CMS

ATTACHMENT B
Historical PMPM and Trend Rates

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

Implementation Plan

**Florida's
Managed Medical Assistance
Program**

October 30, 2013

1115 Research and Demonstration Waiver



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	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.	5
	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), apply to this demonstration.	5
	3. Changes in Medicaid Law, Regulation, and Policy. The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs as needed to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STCs 6 and 7. CMS will notify the state within 30 days of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.....	5
	4. Impact on Demonstration of Changes in Federal Law, Regulation and Policy.	5
	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. In all such cases, the Medicaid state plan governs.	6
	6. Changes Subject to the Demonstration Amendment Process. Changes related to demonstration features, such as, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost-sharing, evaluation design, LIP, 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 of Health and Human Services (“Secretary”) in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS of the amendment to the demonstration. 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. .	6
	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 elements of a viable amendment request as found in these STCs, reports and other deliverables required in the approved STCs in a timely fashion according to the deadlines specified herein. CMS encourages the state to undertake a robust public process to ensure community engagement in the development and submission of amendments to the demonstration. Amendment requests must be accompanied by information that includes but is not limited to the following: 6

8. Extension of the Demonstration..... 7

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 transition and phase-out plan consistent with the requirements of paragraph 9. 7

9. Demonstration Transition and Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements; 8

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 transition and 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 transition and phase-out plan to CMS, the state must publish on its website the draft transition and 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. 8

b. 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. 8

c. Transition and 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 (including those on any applicable wait lists), 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 those beneficiaries whether currently enrolled or on a wait list, determined to be eligible individuals, as well as any community outreach activities, including community resources that are available. 8

d. 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. 8

f. 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 enrollees. 9

10. 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:.....	9
11. 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. ...	9
12. Finding of Non-Compliance. The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.	10
13. 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 enrollees.	10
14. 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.....	10
16. Federal Financial Participation (FFP). No federal matching for administrative or service expenditures for this demonstration will take effect until the approval date identified in the demonstration approval letter.....	11
18. 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.....	11
IV. ENROLLMENT FOR THE MANAGED MEDICAL ASSISTANCE PROGRAM.....	12
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.	13
20. Enrollment in managed care under the MMA program. The MMA program began implementation on April 1, 2014 and is expected to complete implementation in all counties by September 30, 2014. MMA program enrollees are individuals eligible under the approved state plan, who reside in the MMA program regions and who are described below as “mandatory enrollees” or as “voluntary enrollees”. Mandatory enrollees are required to enroll in a capitated managed care plan or FFS PSN as a condition of receipt of Medicaid benefits. Voluntary enrollees are exempt from mandatory enrollment, but have elected to enroll in a demonstration capitated managed care plan or FFS PSN to receive Medicaid benefits.	13
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21. New Enrollees. At the time of their application for Medicaid, individuals who would be mandated to enroll in managed care under MMA 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, and to indicate a plan choice selection if they are prepared to do so. Eligible individuals will be enrolled in a managed care plan upon eligibility determination. If the individual has not selected a plan at the time of the approval of eligibility, the state may auto-assign the individual into a managed care plan. Individuals who have been auto-assigned at enrollment will receive both their managed care plan assignment and information about choice of plans in their area. Such individuals then may actively select a plan during a 120-day change/disenrollment-period without cause post-enrollment. All individuals will be provided with information regarding their rights to change plans. 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..... 15

- 22. Auto-Enrollment Criteria. Each enrollee must have an opportunity to select a managed care plan before or upon being determined eligible for Medicaid. Individuals must be provided information to encourage an active selection electronically or in print. Enrollees who fail to choose a plan by the time their eligibility is determined 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: .16
- 23. 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..... 16
- 24. Lock-In/Disenrollment. Once a mandatory enrollee has selected or been assigned an MMA plan, the enrollee shall be enrolled for a total of 12 months, until the next open enrollment period, unless the individual is determined ineligible for Medicaid. The 12 month period includes a 120-day period upon initial eligibility or re-eligibility determination to change or voluntarily disenroll from a plan without cause and select another plan. If an individual chooses to remain in a plan past 120 days, the individual will be permitted no further changes in enrollment until the next open enrollment period, except for cause. Good cause reasons for disenrollment from a plan are defined in Rule 59-G-8.600, Florida Administrative Code. Voluntary enrollees may disenroll from the plan at any time. 17
- 25. 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 individual will have the same change/disenrollment period without cause as upon initial enrollment..... 17

VI. BENEFIT PACKAGES AND PLANS IN THE MMA PROGRAM 17

- 26. Customized Benefit Packages. MMA plans 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 paragraphs 26-32. For

- other plans, 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.17
- 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, 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.....18
27. **Overall Standards for Customized Benefit Packages.** All benefit packages must be prior-approved by the state and CMS 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. Customized benefit packages, as analyzed through the Plan Evaluation Tool (PET) discussed below, must be submitted to CMS for approval as part of the standard CMS contract review process.18
28. **Plan Evaluation Tool.** The state will utilize a PET to determine if a plan that is applying for, or has been awarded, an MMA plan contract meets state requirements. The PET measures for actuarial equivalency and sufficiency. Specifically, the PET: (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.18
29. **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.....18
30. **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. 19

31. 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. 19

VII. COST-SHARING 19

32. Premiums and Co-Payments. The state must pre-approve all cost-sharing allowed by 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..... 19

VIII. MANAGED MEDICAID ASSISTANCE (MMA) PROGRAM IMPLEMENTATION 19

33. MMA Program Implementation Requirements. The state will continue with the implementation of the MMA program in a region if it meets the following implementation requirements for that region (subject to CMS review and approval). .. 19

34. 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 33. Note: Medicare-Medicaid eligible beneficiaries who are enrolled in a Medicare Advantage plan will participate in an open enrollment period that coincides with the Medicare open enrollment period (October 15 through December 7) to facilitate beneficiaries’ choice of Medicare and Medicaid managed care plans. Therefore, MMA coverage will begin on January 1, 2015 for beneficiaries in both Medicare and Medicaid managed care plans. The MMA program implementation regions are defined as follows:.....20

IX. DELIVERY SYSTEMS 21

35. 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.....21

36. 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.....22

37. Freedom of Choice. An enrollee’s freedom of choice is limited to the providers through whom enrollees may seek services. 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.	22
38. Specialty Plans. Specialty plans may participate in the MMA program.	23
39. 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.	24
40. Requirements for Special Populations.	24
X. CONSUMER PROTECTIONS	25
41. 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 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 110.	25
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 LTSS; 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 (SUD) services.	25
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 110. In addition, each advisory committee must provide input to the state on the consumer report cards, set forth in STC 107.	25
42. 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.	26
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;	26
b. Perform single transactions (individual verifications) or batch transactions via a secure area on the Medicaid fiscal agent's web portal;	26
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;	26
d. Submit eligibility transactions via the Electronic Data Interchange (EDI);	26
e. Contact the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799; or,	26
f. Contact their local Medicaid area office for assistance.	26
48. 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.	27

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.....	27
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.	27
52.	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 82.....	28
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54.	Choice Counseling Defined. The state shall contract for choice counselor services in 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.	28
55.	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.	29
56.	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.....	29
57.	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.	29
58.	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 (AHCA) website or by phone. The state or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended	

hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees. The state must ensure mechanisms are in place to monitor and evaluate choice counseling call center metrics and the individual performance of choice counseling personnel.....29

XII. HEALTHY BEHAVIORS PROGRAM UNDER THE MMA PROGRAM..... 29

- 59. 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.....29

 - 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, an alcohol or substance abuse treatment program that meet all state requirements.30
 - 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.30

XIII. ADDITIONAL PROGRAMS 30

- 64. **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:.....30
- 65. **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).31
- 66. **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.....31

XIV. LOW INCOME POOL 32

- 67. Low Income Pool Definition. In Demonstration Year 10, the LIP provides transitional government support for the safety net providers that furnish uncompensated care to

the Medicaid, underinsured and uninsured populations. In Demonstration Year 11 (SFY 2016-2017) the LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals that are uninsured. Uncompensated care includes charity care for the uninsured but does not include uncompensated care for insured individuals, “bad debt,” or Medicaid and CHIP shortfall. The definition also excludes the estimated impact on uncompensated care that would result from Medicaid expansion, or that has resulted from Marketplace coverage, under the Affordable Care Act. This is reflected in the total computable dollar limit discussed in STC 68.32

68. Availability of Low Income Pool Funds. The following paragraph presents the total computable dollar limit for LIP spending in DYs 10 and 11, subject to assurances.32

a. Total LIP Amount. The total computable dollar limit for LIP expenditures in DY 10 will be \$1 billion. The total computable dollar limit for LIP expenditures in DY 11 will be \$607,825,452 million.32

b. Assurance. As reflected in the LIP participation requirements in STC 77, in DY 11, the state and participating providers who plan to participate in LIP for DY11 will provide assurance that LIP claims include only costs associated with uncompensated care through the provider’s charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that meets the principles of the Healthcare Financial Management Association.32

69. Capped Annual Allotments. All annual LIP funds must be expended by July 31 following each authorized demonstration year. Any amount not expended does not roll over. Capped annual allotment amounts that are not distributed because of penalties, recoupment due to payments exceeding uncompensated care cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the state and not recoverable.....33

70. LIP Reimbursement and Funding Methodology. The Reimbursement and Funding Methodology Document (RFMD) is prepared by the state and documents LIP permissible expenditures, including the non-federal share and the total computable expenditures. The RFMD provides that total computable LIP payments to providers for uncompensated care costs must be supported by uncompensated care costs incurred and reported by providers as charity care on the provider’s financial records. Through the RFMD, the state must demonstrate that it has reconciled LIP payments to auditable costs. LIP provider payments for uncompensated care as charity care are limited to the uncompensated portion of providers’ allowable costs and, in the aggregate, the authorized LIP pool amount for the demonstration year.33

a. Prior to November 30, 2015, the state must submit a draft of DYs 10 and 11 (2016-2017) RFMDs to CMS for approval and CMS will work with Florida towards approval by January 31, 2016. However, Florida may not claim federal financial participation for LIP payments in DY 11 until after a revised RFMD is approved by CMS.33

71. 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.....34

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77. LIP Provider Participation Requirements. Hospitals and Medical School Physician Practices who receive LIP funds have certain participation requirements. If they do not meet the participation requirements, they cannot receive LIP funds. The state may grant an exemption to a hospital of the requirement in (a)(ii) upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan. A letter of denial, or some other comparable evidence, will be required to make such a finding.	35
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ii. Must contract with at least one Specialty Plan serving each specialty population in their corresponding region; and,	36
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iv. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care through the provider’s charity	

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v. In DY 11 for administrative purposes, to participate hospitals must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization based on the ratio of Medicaid days to total patient days reported on the most recent accepted Florida Hospital Uniform Reporting System (FHURS) data.	36
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ii. In DY 11, the state and participating providers will provide assurance that LIP claims include only costs associated with uncompensated care through the provider’s charity care program for individuals with incomes up to at least 200 percent of the federal poverty level that meets the principles of the Healthcare Financial Management Association. Such a charity care program must be established prior to the end of DY 10.	36
iii. In DY 11, participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization	36
78. Deliverable Requirements. CMS will reduce available LIP federal funding on an annual basis for the state’s failure to meet deliverable requirements. A reduction in available LIP federal funding of \$6 million will be assessed annually for each deliverable requirement that is not met. The annual penalty applies to the demonstration year in which the deliverable is due, even if the deliverable itself pertains to a different demonstration year. LIP federal dollars that are lost as a result of deliverable requirements not being met, are surrendered by the state through a CMS-64 adjustment (Summary Line 9D Other). Deliverable requirements include but are not limited to the following:	36
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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.38

83. 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:38

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.40

84. 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.40

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 83 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.40

85. 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 83. On June 24, 2012, the state notified CMS that a transition was not applicable to the demonstration.41

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86. **Quarterly Expenditure Reports: CMS 64.** 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.41

87. **Reporting Expenditures Under the Demonstration: CMS-64.** 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:.....42

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90. 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:	45
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92. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of the demonstration expenditures are met:	46
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97. 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 87 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.	48
98. 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	

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102. 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 84. 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.	49
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available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.	50
104. 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	50
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105. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design and the draft MMA evaluation strategy as part of the amendment or extension approval process. The approved evaluation design and strategy will be part of the amendment or extension approval documents. 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 within 120 days of the end of each renewal period. The state must submit the final evaluation report within 60 days after receipt of CMS’ comments.	52
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107. 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.	53
108. 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.....	53

109. 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.53

110. 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 the MMA program, and managed LTSS. 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. The currently approved Florida CQS may be found at http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml.54

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PLEASE PROVIDE INFORMATION DESCRIBING THE GOAL OF THE DEMONSTRATION, WHAT IT DOES, AND KEY DATES OF APPROVAL/OPERATION. (THIS SHOULD BE THE SAME FOR EACH REPORT.) 1

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I. Executive Summary

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

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

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

A. Waiver Overview

Florida's Section 1115 Research and Demonstration Waiver, entitled "Managed Medical Assistance Waiver," (#11-W-00206/4), is designed to implement a new statewide managed care delivery system that will improve outcomes, improve consumer satisfaction, reduce and control costs and continue the Low Income Pool program. The MMA program will build upon the successful elements of the previous demonstration while incorporating stronger protections for consumers as well as higher standards and more significant positive and negative incentives for plans.

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

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

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

B. Goals and Objectives

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

- Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care by enrolling all Medicaid participants in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care).
- Enhancing fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems. Strict financial oversight requirements are established for managed care organizations (MCOs) to improve fiscal integrity.

C. Consumer Protections

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

1. Increasing recipient participation on Florida's Medical Care Advisory Committee and convening smaller advisory committees to focus on key special needs populations;
2. Ensuring the continuation of services until a primary care or behavioral health provider reviews the enrollee's treatment plan;
3. Ensuring immediate review of recipient complaints, grievances and appeals for resolution as part of the Rapid Cycle Improvement Process;
4. Establishing Healthy Behaviors programs to encourage and reward healthy behaviors and, at a minimum, requiring plans offer a medically approved smoking cessation program, a medically directed weight loss program and a medically approved alcohol or substance abuse recovery program;
5. Requiring Florida's External Quality Review Organization to validate each plan's encounter data;
6. Enhancing consumer report cards to ensure recipients have access to understandable summaries of quality, access and timeliness regarding the performance of each participating managed care plan;
7. Enhancing the plan's performance improvement projects by focusing on six key areas with the goal of achieving improved patient care, population health and reducing per capita Medicaid expenditures;
8. Enhancing metrics on plan quality and access to care to improve plan accountability; and

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

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II. Phased Implementation

A. Implementation Overview

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

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

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

B. Implementation Schedule

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

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

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

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

C. Implementation Triggers, Risks and Mitigation Strategy

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

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

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

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

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

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

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

D. Implementation – Stakeholder's Role

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

E. Rapid Cycle Improvement Process

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

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

F. Comprehensive Outreach and Education Strategy

1. Overall Outreach and Communication Strategy

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

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

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

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

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

2. Recipient Outreach

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

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

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

3. Provider Outreach

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

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

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

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

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

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

4. Other Stakeholder Outreach

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

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

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

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

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

5. Media and the General Public

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

6. Outreach Schedule

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

G. Recipient Enrollment

1. Enrollee Choice

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

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

2. Enrollee Information

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

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

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

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

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

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

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

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

H. Continuity of Care Provisions

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

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

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

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

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

I. Plan Selection

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

The Agency selected 14 standard, non-specialty MMA plans through a competitive procurement process. In addition, the Agency selected five companies to provide services to specialty populations, including specialty plans focused on HIV/AIDS, child welfare and foster care, severe and persistent mental illness, and dual eligibles 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 and 10/24/13)

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

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

**Pending settlement.

² As October 31, 2013, the competitive procurement process used to select the MMA plans has not been finalized.

J. Plan Readiness Review Process

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

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

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

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

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

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

If the Agency finds a plan has:

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

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

K. Plan Contracting

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

1. Contracting Assurances - Provider Network and Access Requirements

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

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

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

In addition, plans are required to establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators and such other information as the Agency deems necessary. The provider database

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

2. Plan Accountability and Performance Standards

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

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

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

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

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

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

3. Penalties and Sanctions

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

If a plan that is awarded an “additional contract” to ensure plan participation in Regions 1 and 2 is subject to penalties pursuant to state law for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan is required to reimburse the Agency for the cost of enrollment changes and other transition activities.

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

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

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Appendix I

Implementation Activities – October 2013

IMPLEMENTATION ACTIVITIES	
1. Plan Selection	<p>Objective: The Agency will develop a plan selection process to ensure contracting with high quality plans that have experience serving the Medicaid population.</p> <p>Status: Completed</p> <ul style="list-style-type: none"> 1.1 Develop procurement evaluation plan. 1.2 Issue MMA Invitation to Negotiate (ITN). 1.3 Appoint and train evaluation team/negotiators. 1.4 Receive MMA bids from potential managed care plans. 1.5 Evaluate plan proposals for mandatory requirements. 1.6 Solicit and evaluate provider input of potential managed care plans. 1.7 Review and evaluate the responses to the MMA ITN with particular attention to the plans' past performance in the provision of health care services and quality improvement. 1.8 Select plans for negotiation and finalize rates in negotiations with plans. 1.9 Select plans and posted MMA awards on Florida's designated procurement site.
2. Comprehensive Outreach and Education	<p>Objective: The Agency will develop and continue to refine a comprehensive outreach and education program to facilitate a smooth transition to the MMA program by ensuring all affected recipients, providers and all stakeholders are informed of changes and the potential impact.</p> <p>Status: In Progress</p> <ul style="list-style-type: none"> 2.1 Develop recipient outreach and education plan. 2.2 Develop provider outreach and education plan. 2.3 Conduct public meetings and workshops for recipients and advocacy groups. 2.4 Conduct public meetings, workshops and webinars for providers. 2.5 Make information available on the Agency's Website, where official documents and updates are posted. 2.6 Publish public notices to announce meetings/workshops to provide updates and obtain public input on the implementation of the MMA program.
3. Plan Readiness Review	<p>Objective: The Agency will develop plan readiness review process and procedures that will ensure the MMA plans are capable of fulfilling all state and federal requirements.</p> <p>Status: Completed 3.1-3.2; In Progress 3.3-3.15</p>

IMPLEMENTATION ACTIVITIES

	<ul style="list-style-type: none"> 3.1 Review the current process and procedures utilized in plan readiness processes. 3.2 Develop plan readiness processes and tools to be utilized with the implementation of the program. 3.3 Appoint readiness review teams and schedule reviews for each region by the staggered implementation timeline. 3.4 Conduct any follow-up financial review and approval. 3.5 Conduct any follow-up organizational and administration review and approval. 3.6 Conduct quality review and approval of policies and procedures. 3.7 Conduct member and provider correspondence review and approval. 3.8 Conduct conductivity testing and file transfer between Agency and plans. 3.9 Review MMA plans' provider credentialing process and conduct provider network review and approval (includes provider, subcontractor, facility, etc.). 3.10 Review MMA plans' Board of Directors/committee meeting minutes and conduct staff interviews. 3.11 Review MMA plans' fraud and abuse program. 3.12 Review MMA plans' staff training plan and schedule. 3.13 Review MMA plans' provider training manual, training schedule, monitoring plan, and schedule. 3.14 Review MMA plans' list of all delegated services and pre-delegation audit reports of those services. 3.15 Complete on-site operational review and review MMA plans' demonstrations of various systems (enrollment/disenrollment, member services, claims processing, report production, case management/care coordination, utilization management, quality improvement, etc.).³
<p>4. Contract Execution</p>	<p>Objective: The Agency will execute contracts with selected managed care plans capable of fulfilling all state and federal requirements.</p> <p>Status: In Progress</p> <ul style="list-style-type: none"> 4.1 Finalize contracts and negotiation agreements. 4.2 Appoint and train designated contract managers. 4.3 Route contracts for signature with the selected MMA plans. 4.4 Record final contract copies with signatures from plans and the Agency. 4.5 Ensure policy and compliance offices have copies of executed contracts. 4.6 Submit certification of actuarially sound rates to the Centers for Medicare and Medicaid Services. 4.7 Submit executed contracts to the Centers for Medicare and Medicaid Services. 4.8 Perform administrative functions to close initial contract process. 4.9 Perform administrative functions to set up FLMMIS provider files.

³ The elements outlined above are not all-inclusive and additional information may be requested at any time during the readiness review process.

IMPLEMENTATION ACTIVITIES

	<p>4.10 Post model contract, plan information and related documents on the Agency’s Website.</p>
<p>5. Recipient Enrollment</p>	<p>Objective: The Agency will implement the enrollment process. The Agency assures that information to potential MMA enrollees will meet requirements under Section 1932(a)(5), Provision of Information.</p> <p>Status: In Progress 5.1; Not Started 5.2 – 5.11</p> <p>5.1 Develop and test auto-assignment algorithm.</p> <p>5.2 Operationalize toll-free hotline with interpretation services, bilingual and multilingual staff, usage of a standardized telephone script and Automated Voice Response System, call monitoring, distribution, scheduling and reporting software, face-to-face and online enrollment processes.</p> <p>5.3 Notify recipients of their new options for MMA plan enrollment.</p> <p>5.4 Initiate choice counseling call center and online enrollment application process.</p> <p>5.5 Mail recipient letters regarding participation in MMA program and 30-day choice period.</p> <p>5.6 Send confirmation letters for enrollees who select a plan 30 days prior to transition date.</p> <p>5.7 Send notification letters to affected enrollees not selecting a plan 30 days prior to transition date.</p> <p>5.8 Process self-selection enrollments through the choice counselor effective the next possible month according to the Agency’s monthly processing cycle.</p> <p>5.9 Process auto-assignment for mandatory recipients who have not selected a plan to be effective the next possible month after the 30th calendar day following the date on the mandatory new eligible letter/auto-assignment letter, according to the Agency’s monthly processing cycle.</p> <p>5.10 Process plan change and disenrollment requests from verified callers, including processing “For Cause” or “Good Cause” changes in accordance with 42 CFR 438.56.</p> <p>5.11 Process plan change within 90 days after enrollment for selection of another plan without cause.</p>
<p>6. Transition Process and Plan Monitoring</p>	<p>Objective: The Agency will implement a transition and monitoring process to ensure continuity of care for recipients transitioning into MMA plans.</p> <p>Status: In Progress 6.1 – 6.2; Not Started 6.3 – 6.13</p> <p>6.1 Analyze existing plans to identify enrollees’ primary care providers to facilitate transition into the MMA plans.</p> <p>6.2 Assist primary care providers (PCPs) unique to existing plans through the Medicaid provider registration process to facilitate an existing PCP’s enrollment in MMA plan networks.</p> <p>6.3 Implement transition plans, including review of provider networks to assess availability of network providers within each region and each plan, for recipients enrolled in the existing programs:</p> <p>6.4 Develop and implement operational transition plan for Agency staff to ensure staff will:</p> <ul style="list-style-type: none"> - Assess capacity of plans. - Coordinate with choice counseling to ensure appropriate and timely notice of plan choice.

IMPLEMENTATION ACTIVITIES

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

Appendix II Draft Comprehensive Outreach Schedule

Timeline	October *2013*				November *2013*				December *2013*			
GO LIVE DATE												
Weeks	10/7-10/11	10/14 - 10/18	10/21-10/25	10/28-10/31	11/1 - 11/8	11/11 - 11/15	11/18 - 11/22	11/25 - 11/29	12/2 - 12/6	12/9 - 12/13	12/16 - 12/20	12/23 - 12/31
Target Outreach Group												
General Public												
Legislature												
Media												
AHCA Staff												
Beneficiaries												
Standard Recipients												
Special Populations												
Providers												
MMA Plans												
MMA Network Providers												
MMA Provider Associations												
All Other Stakeholders												
	Outreach Tool Key:											
PowerPoint / Presentation		Webinar		TV		Radio		Calls		Press Release		
Mail / Letter		Email		Facebook		Twitter		In Person		Newspapers		
YouTube		Website Update										

October 2013

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

November 2013

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

December 2013

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



State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

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Mission Statement
Better Healthcare for All Floridians.