Public Notice Document

Proposed 1115 Research and Demonstration Waiver

Florida's Medically Needy Program

Posted on the Agency's website
(October 11, 2012)

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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A. Statement of Purpose

The State of Florida is requesting a new section 1115 Research and Demonstration Waiver to implement provisions of Florida law enacted in 2011 related to the Medically Needy program. The state is seeking a waiver of specified provisions of the Social Security Act (SSA) in order to provide for costs not otherwise matchable for continuous eligibility for up to 12 months for individuals who become eligible for Medicaid through the Medically Needy program. The state would further request waiver of applicable provisions of the SSA in order to collect a premium in lieu of share of cost (SOC), and not to exceed the SOC amount. Under this proposed demonstration, the criteria for initial eligibility would not be more restrictive than the current Florida Medicaid State Plan criteria, and persons eligible through the Medically Needy program would receive additional months of eligibility, regardless of whether their incurred bills exceeded their SOC amount in the months subsequent to their original eligibility month. Payment of at least part of the premium would be a condition of maintaining eligibility for the full 12 additional months of coverage; however, enrollees would receive a grace period of 90-days of coverage before being disenrolled for non-payment.

B. Current Medically Needy Program

The Medically Needy program is currently authorized by the Florida Medicaid State Plan for persons who would otherwise be eligible except that their family income or assets exceeds the Florida Medicaid State Plan threshold for Medicaid eligibility. Currently, in the event that subtracting the amount of allowable medical expenses incurred by these individuals from their monthly income would cause the remainder to fall below the Medically Needy Income Level (MNIL), these individuals become eligible for Medicaid. The MNIL is currently based on the amount of maximum monthly cash benefit paid to recipients of Temporary Assistance for Needy Families (TANF)[1].

For TANF eligible assistance groups, all persons in the assistance group become eligible for Medicaid on the date that incurred medical expenses would cause the assistance group income to fall below the MNIL. For SSI-related individuals and spouses, the eligible individual or eligible couple become eligible when the incurred medical expenses cause the countable income to fall below the MNIL. For purposes of this document “Medically Needy recipient” will be used to describe individuals, eligible assistance groups and SSI related individuals and spouses who have become eligible through the Medically Needy program.

Eligibility is restricted to individuals or families with limited assets, such as savings or property (other than a residence). Under this proposed concept, the current income levels and asset limits would not change. The current Medically Needy Income Limits and Resource Limits are shown in Table 1.

[1] The TANF limit is the same as the AID to Families with Dependent Children (AFDC) income limit in effect as of July 12, 1996

Table 1 Medically Needy Income Limits and Resource Limits by Family Size		
Family Size	**Medically Needy Income Level** (Monthly)	**Resource Limits**
1	$180	$5,000
2	$241	$6,000
3	$303	$6,000
4	$364	$6,500
5	$426	$7,000
Additional persons	Increases by $61 or $62 per person	Increases by $500 per person

The difference between the family's income and the MNIL is called the SOC. Currently, when the assistance group incurs medical expenses sufficient to reduce available income below the MNIL for that month, the Medically Needy recipient(s) in the assistance group meet the SOC and are eligible from the day the SOC is met through the end of that month only. Medical expenses incurred before the day that SOC is met are not paid by Medicaid and remain the responsibility of the assistance group. On the date the SOC is met, the Medically Needy individuals in the assistance group become eligible for fee-for-service (FFS) Medicaid for the balance of the month and medically necessary expenses are reimbursed by Medicaid.

The Medically Needy program covers all medical services covered by Florida Medicaid except for long-term care (skilled nursing facility care, services in an Intermediate Care Facility for the Developmentally Disabled and services under a home and community-based waiver). Eligibility for the Medically Needy program is determined by the Florida Department of Children and Families (DCF) and payment for provision of services is administered by the Agency for Health Care Administration (Agency), the state's designated single state agency under Title XIX.

The Medically Needy program was implemented in Florida in 1986 and since that time the Florida Legislature has considered a myriad of changes to coverage of this optional population. Although full coverage for all Medicaid services (except long-term care) for eligible recipients has continued through the present, changes to limit the types of services, covered groups and even elimination of the program have been considered (see the following "State Law" section for specific provisions passed by the Florida Legislature during the 2011 session).

Currently, the Medically Needy program serves an average of 48,158 individuals during any month, and provides services for at least one month to more than 250,000 individuals annually. Total expenditures for Medicaid services reimbursed for the program for State Fiscal Year (SFY) 2010-11 were $808.6 million, and costs for the program for SFY 2011-12 are estimated to be $938.6 million.

C. State Law

Prior to the 2011 legislative session, section (s.) 409.904(2)(a), Florida Statutes (F.S.), authorized the Medically Needy program and provided for the program to expire on June 30, 2011. During the 2011 legislative session, the Legislature considered several alternative approaches to the Medically Needy program. In the bills (House Bills 7107 and 7109) that were enacted, the Legislature continued the Medically Needy program and directed the Agency to seek federal waiver authority to change the program to provide additional months of

coverage, to implement a premium that would not exceed the share of cost and to provide care coordination and utilization management to achieve more cost-effective services.

Specifically, House Bill 7107 that was enacted in the 2011 session made significant changes to the Medically Needy program. The specific Medically Needy statutory provisions are as follows:

- Section 409.972(1), Florida Statutes (F.S.), provides that persons eligible for the program known as "Medically Needy" pursuant to s. 409.904(2) shall enroll in managed care plans. Medically Needy recipients shall meet the share of the cost by paying the plan premium, up to the share of the cost amount, contingent upon federal approval.
- Section 409.975(7), F.S., MEDICALLY NEEDY ENROLLEES. This section provides that each managed care plan must accept any Medically Needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. After the first month of qualifying as a Medically Needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee's share of the cost as determined by the department. The agency shall pay any remaining portion of the monthly premium. Plans are not obligated to pay claims for Medically Needy patients for services provided before enrollment in the plan. Medically Needy patients are responsible for payment of incurred claims that are used to determine eligibility. Plans must provide a grace period of at least 90 days before disenrolling recipients who fail to pay their shares of the premium.

D. Program Goals

The goal of the new Medically Needy program is to extend Medicaid eligibility to people who are categorically eligible for Medicaid (i.e., children and parents, persons who are elderly, blind or disabled), but who are not eligible for Medicaid due to income or assets that exceed the limits established in the Florida Medicaid State Plan. Those individuals who incur medical expenses that, when subtracted from their countable income, would reduce their income below the MNIL are currently eligible for Medicaid through the Medically Needy program on a month-to-month basis. The proposed waiver will modify the operation of the Medically Needy program to allow Medically Needy recipients to receive services through the Managed Medical Assistance (MMA) program as specified in sections 409.972(1) and 409.975(7), F.S.

The Agency seeks to continue to serve this population by providing access to continuous enrollment in Medicaid managed care, require recipient cost sharing and to reduce costs by:

a) Removing incentives for individuals to continue to incur inefficient medical costs such as accessing treatment in the emergency room rather than treatment in a less costly setting in order to qualify for eligibility.

b) Extending eligibility to twelve month periods rather than recertifying recipients each month; and

c) Providing coordinated and appropriate use of medically necessary services reimbursed by Medicaid for this population.

E. Program Objectives

The proposed demonstration waiver seeks to improve the effectiveness of the Medically Needy program by providing access for this population to an integrated service delivery system of health care. Using a coordinated approach to care will address a number of unintended consequences of the current program and provide for opportunities for increased access to care, simplified eligibility determination and improved continuity of care delivery in the most efficient and effective setting.

As previously described, Medicaid applicants who are otherwise eligible for Medicaid, but who do not qualify due to income and assets that exceed the standard level for eligibility, cannot receive services reimbursed by Medicaid until SOC is met and then become eligible. Under the proposed demonstration, the Medically Needy program will:

- Provide for the enrollment of persons eligible for the Medically Needy program in managed care plans operated under the MMA program;
- Provide that individuals are responsible for payment of incurred claims (up to the SOC amount) that are used to determine eligibility,
- Improve the continuity of care for persons eligible for the Medically Needy program through the provision of up to 12 months of continuous enrollment;
- Provide for recipient payment of a premium not greater than the calculated SOC after the first month of qualifying for the program, with continued enrollment of up to 12 months, contingent on payment of the premium;
- Provide that the Agency shall pay any portion of the premium that exceeds the recipient's SOC; and
- Provide for a grace period of at least 90 days before disenrolling recipients who fail to pay their share of the premiums.

Specific Objectives

The proposed objectives of the waiver will:

1. Provide incentives to providers and recipients for efficient utilization of services by providing for the ability of continuous eligibility and requiring recipient cost sharing through a premium arrangement not to exceed the current SOC amount.
2. Require eligibility determination only once each 12 months rather than meeting SOC monthly.
3. Provide recipients with a three-month grace period before they can be disenrolled from the plan for non-payment of their premiums, to ensure coordination of care.
4. Provide the managed care providers assurances that recipients are eligible for up to a 12-month period.
5. Provide recipients access to care coordination and remove the incentive for the emergency room to be a first choice of setting for medical care in order to qualify for eligibility.

II. Program Description

A. Medically Needy Program

The following provides a description of the Medically Needy program and the integrated health care delivery system (MMA program) through which the Medically Needy recipients will receive their Medicaid services as specified in Florida law. Please note that on August 1, 2011, the Agency submitted an amendment to Florida 1115 Medicaid Reform Waiver to implement the MMA program. A detailed description of the MMA program can be viewed at the below link. The Agency continues to work with the Centers for Medicare and Medicaid Services (Federal CMS) to obtain approval of the amendment to implement the MMA program.

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Amendment_1_1115_Medicaid_Reform_Waiver_08012011.pdf

B. Eligibility

Under this proposed waiver, the criteria for initial eligibility for the Medically Needy program would not be more restrictive than the current Florida Medicaid State Plan criteria and persons who become eligible through the proposed Medically Needy program would receive additional months of eligibility through enrollment in the MMA program, regardless of whether their incurred bills exceeded the SOC amount in the months subsequent to their original eligibility month.

Table 2 summarizes the groups eligible for the Medically Need program.

Table 2
Summary of Groups Eligible for the Medically Needy Program

Group	Medicaid Eligibility	Medically Needy
Infants (under age 1)	Up to 185% of FPL	Individuals not Medicaid eligible due to income or assets who are part of an assistance group with incurred medical expenses that, when subtracted from income, fall below the Medically Needy Income Limit. The MNIL is based on assistance group size: 1-$180, 2-$241, 3-$303, 4-$365, etc.
Children under age 6	Up to 133% of FPL	
Children age 6 through 17	Up to 100% of FPL	
Children age 18 and 19	Dependent children age 18 or 19 and in school can be eligible if family income is below 19% of FPL (51% with earnings disregard). Current or former foster children are eligible without regard to income to age 21.	
Parents	Up to 19% of FPL (51% of FPL with earnings disregard)	
Individuals who are Aged, Blind or Disabled	Up to 75% of FPL for an individual or up to 83% of FPL for a couple.	
Childless Adults (Not Aged, Blind or Disabled)	Not eligible	Not eligible

Initial Eligibility

In the month in which the household becomes eligible by incurring medical expenses sufficient to meet the SOC, the medical expenses for the balance of the month will be paid through the FFS system. The Medically Needy recipients in the household will be subsequently enrolled in the MMA program as outlined below. In any months between the household meeting the SOC and enrollment in the managed care plan, the Medically Needy recipients would only become eligible by the household incurring medical expenses sufficient to meet the SOC.

C. Plan Enrollment and Disenrollment

Upon implementation of the MMA program, the Agency will transition eligible recipients in each region on a staggered basis into the managed care plans.

The Agency will carefully plan the transition of the affected Medically Needy recipients into the MMA program to preserve continuity of care. The Agency will follow a multi-layered approach in the design of the transition plan by:

- Assessing the capacity of the contracted plans to ensure continuity of care.
- Coordinating with the contracted plans and the Agency's designated choice counselor to create a staggered transition to ensure that the volume of Medically Needy recipients being transitioned occurs in an organized manner.
- Coordinating with the new contracted plans, the Agency's designated choice counseling vendor, local area office staff and advocacy groups in ensuring appropriate and timely notice to Medically Needy recipients, including developing and releasing flyers to locations and providers frequented by impacted recipients to help ensure recipients understand the changes that are occurring to the Medically Needy program.

1. Medically Needy Recipients:

At the time a Medically Needy household becomes eligible by meeting the household's SOC, the eligible Medically Needy recipients will receive information about the managed care plan choices in their area. The Medically Needy recipients will be informed of their option to select a plan within 30 days of being determined eligible for Medicaid and the Medically Needy program. Twelve months of continuous Medicaid coverage is not available to Medically Needy recipients until they are enrolled in a managed care plan. Once Medically Needy recipients have made their choice, they will be able to contact the Agency or the Agency's designated choice counseling vendor to register their plan selection or complete enrollment through the online process. Recipients can also use the enrollment form to mail in their selection. If the recipient does not select a plan within the 30-day period, the Agency will assign the Medically Needy recipient to a managed care plan.

2. Assignment

Each Medically Needy recipient will be given 30 days to select a managed care plan after being determined eligible for Medicaid and the Medically Needy program. Within the 30-day period, the Agency or the Agency's designated choice counseling vendor will provide information to recipients to encourage an active plan selection. Recipients who fail to choose within this timeframe will be assigned to a plan in their region.

When automatically enrolling a Medically Needy recipient into a plan, the Agency will seek to preserve an existing provider relationship by considering whether the recipient has received services from one of the primary care providers in the plan's provider network in the past.

3. Lock-In/Disenrollment

Once a mandatory Medically Needy recipient has selected or been assigned to a managed care plan, the enrollee will have 90 days in which to voluntarily disenroll and select another managed care plan. After 90 days, the enrollee will be locked-in for the remainder of the 12 month period and no further changes may be made until the next open enrollment period, except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of primary care providers, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between primary care providers within the same managed care plan.

The Agency or the Agency's designee will record the managed care plan change/disenrollment reason for all Medically Needy recipients who request such a change. The Agency or the Agency's designee will be responsible for processing all enrollments and disenrollments.

For the Medically Needy recipients, failure to pay the monthly premium will result in disenrollment from the managed care plan, the Medically Needy program and Florida Medicaid. The Medically Needy recipient receives a 90-day grace period for non-payment of premium before being disenrolled from the managed care plan, the Medically Needy program and Florida Medicaid.

For Medically Needy recipients who become categorically eligible for Medicaid while enrolled in the Medically Needy Waiver and are determined to be mandatory for participation in the MMA program the recipients will be: disenrolled from the Medically Needy Waiver, enrolled in the MMA Program Waiver, remain in their MMA plan for their Medicaid services to ensure continuity of care and not have to pay a monthly premium.

The Agency assures Federal CMS that it complies with Section 1932(a)(4) and 42 Code of Federal Regulations (CFR) 438.56, insofar as the provisions are applicable.

4. Re-enrollment

In instances of a temporary loss of Medicaid and Medically Needy eligibility, which the Agency is defining as six months or less, the Agency will re-enroll the Medically Needy recipients in the same managed care plan they were enrolled in prior to the temporary loss of eligibility. The Agency believes that such re-enrollment will promote increased use of preventive services, maximize continuity of care and foster continued provider relationships.

D. Information and Choice

1. Enrollee Choice

Potential enrollees will have a choice of two or more managed care plans in each region. The Agency assures Federal CMS that it will comply with section 1932(a)(3) and 42 CFR 438.52, relating to choice, since at least two options will be available in all demonstration regions. Recognizing the unique attributes of Florida's rural communities, the Agency will issue regional bids to ensure that individuals will have two or more plan options.

2. Enrollee Information

The Agency or the Agency's designated choice counseling vendor will ensure that Medically Needy recipients are provided with full and complete information about their managed care plan options. The Agency or the Agency's designated choice counseling vendor will provide information regarding an individual's choice of managed care plans.

The Agency will develop Medically Needy enrollee education 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 or the Agency's designated choice counseling vendor will provide information on selecting a managed care plan.

Enrollment materials will be provided in a variety of ways including print, telephone, online and face-to-face. All written materials shall be at or near 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 or the Agency's designated choice counseling vendor will also provide oral interpretation services, regardless of the language and other services for impaired recipients, such as TTD/TTY. Individuals will be able to contact the Agency or the Agency's designated choice counseling vendor to obtain additional information. The Agency or the Agency's designated choice counseling vendor 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 staff qualified and trained to address the needs of the enrollees and potential enrollees.

The Agency assures Federal CMS that it will provide information in accordance with Section 1932(a)(5) of the Act and 42 CFR 438.10, relating to Information Requirements.

The Agency or the Agency's designated choice counseling vendor will retain responsibility for all enrollment and disenrollment activities into managed care plans.

E. Benefits

The MMA program will provide Medically Needy recipients with health care options that will allow them to better manage their health care. Currently, the Medicaid benefit package is one-size-fits all, leaving Medicaid enrollees with a single option for services, regardless of need. In many of the benefit "silos" that exist today, there are statewide limits and caps on various services that have varying impact on local populations.

1. Customized Benefit Packages

A major element of the MMA program is the ability of managed care plans to develop customized benefit packages targeted to specific populations. These customized benefit packages will foster enrollee choice and will enable enrollees to access the health care services they need. Additionally, it is expected that these customized benefit plans will resemble commercial insurance plans, further bridging public and private coverage.

The benefit packages may look different from traditional Medicaid in several ways. In order to provide additional or special services to the targeted population, these tailored benefit packages may vary the amount, duration and scope of some services and may contain service-specific coverage limits, such as the number of visits or dollar cost. All packages must cover mandatory Medicaid services, including medically necessary services for pregnant women and early and periodic screening and diagnosis and treatment (EPSDT) services for children under age 21, as the Agency is not seeking to waive EPSDT requirements for children enrolled in a Medicaid managed care plan. It is also expected that managed care plans will develop benefit packages to cover most optional services. In addition, managed care plans may also cover services not currently offered under Florida Medicaid State Plan, such as adult preventative dental care. Services not included in an approved benefit package, or that exceed those in an approved benefit package, will be considered non-covered services.

All benefit packages must be prior-approved by the Agency and must be at least actuarially equivalent to the services provided to the target population under the current Florida Medicaid State Plan benefit package. In addition to being actuarially equivalent to the value of traditional Medicaid services, each managed care plans customized benefit package must pass a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population (e.g., TANF, aged and disabled, etc.).

While one of the major principles of the Agency is to encourage innovation by allowing for the variation of amount, duration and scope, plans are not required to change benefit packages and may choose to offer a benefit package that mirrors current coverage levels. Actual benefit packages will depend on market innovation and the population the plan seeks to serve and will be reviewed annually by the Agency.

a. Actuarial Equivalency

The Agency will evaluate each proposed customized benefit plan for actuarial equivalence to the current Medicaid State Plan. To do this, the Agency will use a Benefit Plan Evaluation Model that: 1) compares the value of the level of benefits in the proposed package to the value of the current Florida Medicaid State Plan package for the average member of the population and 2) ensures that the overall level of benefits is appropriate.

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 will ensure that, given a specified Medicaid target population and its historical utilization, 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. The Agency will use this as the first threshold to evaluate the customized benefit package submitted by a managed care plan to ensure that the package earns the premium established by the Agency. In assessing actuarial equivalency, the evaluation model will consider the following components of the benefit package: services covered; cost sharing; additional benefits offered, if any; and any global limits.

b. Sufficiency

In addition to meeting the actuarial equivalence test, each managed care plans proposed customized benefit package must meet state-established standards of benefit sufficiency. These standards will be based on the target population's historic use of Medicaid State Plan services. In this evaluation, the Agency will identify specific services (e.g., inpatient hospital,

outpatient physician care, behavioral health and prescription drugs) and will evaluate each proposed benefit plan against the sufficiency standard to ensure that the proposed benefits are adequate to cover the needs of 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 managed care plans proposed benefit level.

Thus, in order for a managed care plan to obtain Agency prior approval of its proposed customized benefit package, the proposed benefit package must be actuarially equivalent to the current Medicaid State Plan benefits for each target population and must cover key benefits at a level sufficient to meet the needs of the target population. Recipients will have the option to choose a managed care plan with a benefit package that best fits their needs. For example, one managed care plans benefit package may offer fewer chiropractic visits and more vision benefits than another managed care plans benefit package. If the recipient does not need a chiropractor, but wears glasses, he/she may wish to choose a managed care plan with a benefit package that offers more vision benefits. The flexibility to offer customized benefit packages, combined with the two-pronged Benefit Plan Evaluation Model, will ensure optimal benefit packages for plan enrollees.

The Agency will evaluate service utilization on an annual basis and use this information to update the benefit comparison package to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

2. Cost Sharing

Under the MMA program, the contracted plans may impose cost-sharing requirements consistent with the currently approved nominal levels in the Florida Medicaid State Plan. Table 3 provides the current cost-sharing, including co-payments and co-insurances.

Table 3
Co-payment/Co-insurance

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

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

3. Medically Needy Enrollee Premiums

Florida law requires that each managed care plan must accept any Medically Needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. In the first month of enrollment a plan, the recipient shall not be required to pay a portion of the monthly premium. After the first month of qualifying as a Medically Needy recipient and enrolling in a plan and contingent upon Federal CMS approval, the recipient shall pay the managed care plan a portion of the monthly premium equal to the recipient's share of the cost as determined by DCF. The Agency shall pay any remaining portion of the monthly premium. If the monthly premium is lower than the Medically Needy recipient's SOC, the recipient will be responsible for paying the entire premium and the Agency will not be responsible for paying any portion of the premium to the plan. The managed care plans are not obligated to pay claims for Medically Needy recipients for services provided before enrollment in the plan. Medically Needy recipients are responsible for payment of incurred claims that are used to determine eligibility for the Medically Needy program. The managed care plans must provide a grace period of at least 90-days before recipients who fail to pay their shares of the premium are disenrolled by the Agency.

4. Healthy Behaviors

As part of the procurement process in 2013, each selected managed care plan shall be required to establish a program to encourage and reward healthy behaviors. Consistent with state law, at a minimum each plan must establish a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment program.

F. Health Care Delivery Systems

1. Managed Medical Assistance Program

Florida's MMA program is designed to operate statewide and will be guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. The Medically Needy recipients through this waiver will be mandated to participate in the MMA program to receive their health care services.

The MMA program will introduce more individual choice, increase access and improve quality, efficiency and fiscal integrity while stabilizing cost. The MMA program is an integrated model to manage all care and will increase the enrollment of recipients including the Medically Needy

population in comprehensive managed care plans that are capable of coordinating all of an individual's care.

2. Regions

Florida law established 11 regions throughout the State of Florida for the MMA program, and outlines the number of managed care plans authorized to provide services in each region. Table 4 provides a list of the counties by the 11 regions.

Table 4
Regions for the MMA Program

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

3. Procurement Method

Under the MMA program, the Agency will competitively procure the managed care plans to provide services to all eligible Medicaid recipients, including the Medically Needy population. The Agency will initiate separate but simultaneous procurements in each of the 11 regions of the state with full implementation by October 1, 2014.

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

- Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body;
- Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations;
- Availability and accessibility of primary care and specialty physicians in the provider network;
- Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services;
- Commitment to quality improvement;
- Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and

- Documentation of policies for preventing fraud and abuse.

The Agency is directed to enter into five-year health plan contracts with selected managed care plans. The Agency may not renew the contracts and may extend the term of the contact only in order to cover any delays in transitioning to a new plan, but the contract may not be renewed.

4. Managed Care Plans Defined

Under the MMA program, a managed care plan is defined as an eligible plan under contract with the Agency to provide services in the Medicaid program, and a prepaid plan is defined as a managed care plan that is licensed or certified as a risk-bearing entity in the state, or qualified pursuant to Florida law, that is paid a prospective per-member, per-month payment by the Agency.

An "eligible plan" is defined as a health insurer authorized under Chapter 627, F.S., an Exclusive Provider Organization authorized under Chapter 627, F.S., a Health Maintenance Organization authorized under Chapter 641, F.S., a Provider Service Network (PSN) authorized under state law, an ACO authorized under federal law, or the Children's Medical Service (CMS) Network authorized under Florida law.

5. Number of Plans per Region

The Agency will procure a specified number of MMA plans per region. Florida law specifies a minimum and maximum number of managed care plans, along with the requirement that, of the total contracts awarded per region, at least one plan shall be a PSN if any PSNs submit a responsive bid.

Issuance of the procurement will provide for a choice of plans, as well as, market stability as the Agency will enter into five-year contracts. As noted in Table 5, there will be a minimum of two managed care plan choices in each of the 11 regions of the state. To the extent that there are fewer than two managed care plan choices in an area, the Agency will issue a procurement to obtain a second managed care plan and meet the federal requirements regarding choice until two managed care plans are available.

Table 5
MMA Plans per Region

	Min # of Plans	Max # of Plans	Min # of PSNs
Region 1	2	2	1
Region 2	2	2	1
Region 3	3	5	1
Region 4	3	5	1
Region 5	2	4	1
Region 6	4	7	1
Region 7	3	6	1
Region 8	2	4	1
Region 9	2	4	1
Region 10	2	4	1
Region 11	5	10	1

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

6. Plan Selection Criteria

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

8. Reimbursement

The Agency will reimburse most contracted plans on a capitated basis; however, FFS payments may be used for PSN providers for a time-limited period as authorized in State law.

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

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

The purpose of health-based risk adjustment is to provide a risk score for each individual receiving services through Medicaid which reflects their predicted health care needs. The scores of all of the individuals enrolled in each plan determine the collective risk score and the resulting premiums for that plan. The state will work with its contracted actuary to update and enhance risk adjustment methodologies to reflect nationally recognized models best suited for this program.

The Agency assures Federal CMS that premiums will be established in accordance with 42 CFR 438.6 and certified by an actuary. The Federal CMS Regional Office will review and approve all capitation rates in accordance with 42 CFR 438, insofar as the requirement is applicable.

The Agency may pay some or all PSNs on a FFS basis as authorized by Florida law, using historical Medicaid covered services with no variation of benefit package. The Agency will not

reimburse a FFS-based PSN for services not authorized under the Florida Medicaid State Plan. PSNs may provide and directly pay for additional services through any savings earned at no cost the state.

G. Accountability and Monitoring

The Agency will follow standard state contracting procedures to enter into clear and comprehensive managed care contracts developed prior to procurement that are consistent with all state and federal requirements. The Agency will specify monitoring activities and contractual accountability standards to ensure access to and the delivery of high quality health care by all contracted managed care plans to enrollees. 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 and promoting quality and cost-effective delivery of services.

1. Provider Network Requirements

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

In order to ensure access to necessary Medicaid services, the Agency is directed to establish specific standards for the number, type and regional distribution of providers in managed care plan networks. The Agency will ensure that plans maintain a network of providers in sufficient numbers to meet the needs of the recipients. Specifically, the managed care 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. Managed care plans will be required to have providers available within reasonable travel and distance standards comparable to standards established by the Agency.

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. Furthermore, the Agency will evaluate each plan's pharmacy network to assure reasonable access.

In addition, as previously noted, the Agency is directed, when selecting managed care plans based on ITN responses, to evaluate those responses, in part, based on the availability and accessibility of primary care and specialty physicians in the network and the establishment of partnership with community providers that provide community based services.

In addition, managed care plans will be required to establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators and such other information as the Agency deems necessary. The provider database must be available online to both the Agency and the public 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 will enhance 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 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. The Agency will conduct periodic contract oversight and monitoring reviews to ensure plan compliance with contract requirements and develop a thorough and consistent oversight review process so that plans are held to consistent standards.

3.Grievance and Appeals

The Agency will maintain and ensure a grievance process for plans that:

- Requires each plan to have an approved internal grievance system that is consistent with federal law and allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for, services as required by section 1932(b)(4) of the SSA and 42 CFR 438 Subpart H and Subpart F Grievance System, in-so-far as these regulations are applicable.

- Maintains a state-level panel to hear appeals of grievances not resolved at the plan level.

- Preserves the Medicaid fair hearing process that requires each Medicaid managed care plan to provide Medicaid enrollees with access to the State Fair Hearing process as required under 42 CFR 431 Subpart E, including:

  - Informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
  - Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if the state takes action without the advance notice and as required in accordance with State policy consistent with Fair Hearings. The state must also inform enrollees of the procedures by which benefits can be continued or reinstated- and
  - Other requirements of Fair Hearing found in 42 CFR 4331, Subpart E.

4. Program Integrity

The Agency assures that the Medicaid program integrity system will require each managed care plan to comply with Section 1932(d)(1) of the SSA and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State will prohibit any of the managed care plan from knowingly having a relationship with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

2. An individual who is an affiliate, as defined in the Federal Acquisition Regulations, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the managed care plan,
2. A person with beneficial ownership of 5% or more of the managed care plan's equity,
3. A person with an employment, consulting or other arrangement with managed care plan for the provision of items and services that are significant and material to the managed care plan's obligations under its contract with the State.

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

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

The payments to each managed care plan will be required to be in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

H. Sanctions

To ensure stability, the Agency will impose new penalties for managed care 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 provider services networks must pay a per enrollee penalty of up to three months payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another managed care plan, whichever occurs first. In addition to payment of costs, all other 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 to terminate all contracts with that plan in other regions.

If the Agency terminates a contract with a managed care plan for a region or regions, the Agency will develop a plan to transition enrollees to other plans and may phase-in the terminations over a time period sufficient to ensure a smooth transition for affected enrollees. Such transition plans shall consider transition of enrollees under case management and those with complex medical needs, and existing provider or care relationships.

I. Quality Initiatives

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

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

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

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

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

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

The Agency assures Federal CMS that it complies with Section 1932(c) of the Act and 42 CFR 438.200, Quality Assessment and Performance Improvement. All plans will be required to comply with applicable provisions.

The Agency will develop or adopt additional performance measures in response to features of the MMA Program to promote quality of care. When possible, established measures with available benchmark data, such as HEDIS, will be preferentially selected. Managed care plans will be required to report annual audited performance measures that include both HEDIS and

HEDIS-like or Agency-defined measures and this reporting will continue under the MMA program.

Additionally, managed care plans will be required to set performance standards for their network providers and determine continued network participation based on achievement with those standards.

In an effort to improve quality of care, the Agency adopted high standards, as defined by the NCQA National Means and Percentiles, as the performance target for each of the HEDIS measures that managed care plans are required to report. The strategies adopted by the Agency aim to bring the statewide level of performance in line with that performance target. To accomplish this goal, the Agency will require the development of a strategy that requires managed care plans to develop corrective action plans to address deficient scores. Failure to comply with the terms of their internally developed corrective action plans or failure to improve scores to minimal levels as set by the Agency will result in monetary penalties. The Agency will also develop an incentive program to reward higher performing health plans. Such incentives may include additional auto-assignments each month and a financial incentives to encourage continual improvement.

Managed care plans must participate in the activities of the External Quality Review Organization, which include validation of performance measures, validation of performance improvement projects and reviews of compliance with standards. Managed care plans will be required to develop and document a Quality Improvement Plan (QIP) that guides the efforts that will be taken at the managed care plan level to improve quality in both clinical and non-clinical areas of operation. As part of the MMA program plan, the QIP will be required to include enrollee satisfaction and disenrollment surveys. The Agency reviews and approves the managed care plans' QIPs. Managed care plans will be required to conduct Performance Improvement Projects (PIPs) in content areas specified in contracts.

All capitated managed care plans, as well as FFS PSNs that are capitated for non-emergency transportation, must submit encounter data to the Agency that reports services provided to enrollees under the contract. Data must be reported in a Health Insurance Portability and Accountability Act (HIPAA)-compliant X12 format and must meet minimum quality standards for processing through the state's Medicaid Management Information System. Non-compliant managed care plans can be assessed a penalty for failure to submit data accurately and timely.

The Agency will utilize encounter data to conduct quality of care studies and evaluations of services provided to recipients enrolled in the MMA program. As the program is developed, the Agency will identify areas of particular interest for studies, but will include, at a minimum, studies regarding access to care, appropriateness of care and fraud and abuse. The Agency will also impose fines for failure to comply with encounter data reporting requirements. If the plan fails to comply within certain timeframes, the Agency will assess a daily fine for each day of non-compliance beginning on the 31st day. In addition, the Agency will notify the plan that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

III. Program Financing

With the implementation of the proposed Medically Needy program, case months are expected to grow by over 300% as compared to current program projections, but the total per capita monthly cost is expected to drop from just over $1,000 to approximately $450. This significant drop is the result of several factors: adding eligibility months that represent more moderate costs to the current single high-cost eligibility month and a moderation of costs associated with improved incentives and care management tools. Enrollees are expected to pay on average $118 per month, which will never exceed any individual's SOC. The combination of lower average monthly cost and the enrollee premium contributions are expected to offset the cost of the additional case months, producing budget neutrality for federal expenditures.

These estimates are based on populations eligible for the proposed Medically Needy program, which include most Medically Needy coverage groups but do not include coverage related to foster care, emergency Medicaid for Aliens, presumptively eligible newborns and Refugee Assistance/Cuban-Haitian Entrants. The estimated caseload change and total costs for the proposed program reflect an assumption that all eligible individuals pay premiums and remain enrolled in the program for the full 12 months of eligibility. The estimated enrollee monthly premiums reflect an average amount with consideration that enrollees will pay the lesser of the premium benchmark or their share of cost, and will not pay a premium during the initial qualifying month. Premium benchmarks will be developed by the Agency's actuaries and based on historical experience of Medically Needy and other similar populations.

IV. Research Hypotheses and Evaluation

A. Research Hypotheses

The following are the research hypotheses for the proposed 1115 Research and Demonstration Waiver for the Medically Needy program.

Hypothesis #1:

The proposed Medically Needy program successfully extends Medicaid eligibility to the Medically Needy population and effectively enrolls them in a managed care plan (see Eligibility and Enrollment).

Hypothesis #2:

The proposed Medically Needy program successfully provides continuity of care to the Medically Needy eligible population (see below Continuity of Care and SOCs).

Hypothesis #3:

Budget neutrality is maintained (see Budget Neutrality).

B. Evaluation Plan

The goal of the new Medically Needy program is to extend Medicaid eligibility to people who are categorically eligible for Medicaid (i.e., children and parents, persons who are elderly, blind or disabled), but who are not eligible for Medicaid due to income or assets that exceed the limits established in the Florida Medicaid State Plan. Those individuals who incur medical expenses that, when subtracted from their countable income, would reduce their income or assets below the MNIL are currently eligible for Medicaid through the Medically Needy program on a month-to-month basis. The proposed program seeks to prove that, by providing for access to 12 months of continuous enrollment in Medicaid managed care and requiring premium from recipients, the program would remain budget neutral while improving access to care. There are three main areas of focus for the evaluation: Eligibility Expansion and Enrollment, Continuity of Care, and SOC.

1. <u>Eligibility Expansion and Enrollment</u>

The goals of the proposed Medically Needy program cannot be met without effectively enrolling eligible persons. The following research questions/outcome measures will provide an assessment of the effectiveness of implementation for the proposed Medically Needy program.

Research Questions:

- What is the number of Medically Needy eligible persons in Florida?
- What is the number of Medically Needy eligible successfully enrolled in managed care plans?
- What is the percentage of Medically Needy eligible enrolled?
- What is the comparison of actual versus projected enrollment and Analysis of Difference?

2. Continuity of Care

In order to evaluate the effectiveness of continuity of care, it is necessary to determine whether the goal of continuity of care is met and whether the continuity of care results in the intended outcomes. The following research questions are designed to measure the effectiveness of the program at providing continuity of care as well as providing insight into the effectiveness of continued enrollment.

Research Questions:

- How many enrolled Medically Needy recipients maintain eligibility for 12 months? Check for continued eligibility at 3 or 6 month intervals.
- What is the average length of enrollment in a managed care plan?
- Do Medically Needy recipients enrolled in a managed care plan actively seek care?
- How do patterns and costs of care compare to the pre-waiver Medically Needy population?

3. Share of Costs

The premium payment is meant to add stability to the SOC requirement under the Medically Needy program. The premium structure should therefore encourage stability in enrollment, provide no extra costs over existing requirements and should be easily administered. The following research questions will help identify the effectiveness of the premium provisions.

Research Questions:

- Do Medically Needy enrollees pay their premiums?
- What is the pattern of premium payment?
    - Percentage that pay on time
    - Percentage that pay late
    - Percentage that maintain arrearages for premium payments
- How many are disenrolled for failure to pay premium?
    - Number and percentage disenrolled for premium non-payment
    - Number and percentage disenrolled for other reasons

4. Budget Neutrality

The Agency will report budget neutrality as approved by Federal CMS.

Data Sources

The analyses will be based on the program data including eligibility and enrollment files and managed care plan encounter data for the Medically Needy program.

Evaluation Interim and Summary Reports

The evaluation will include at least one interim report due annually within 90 days of the end of the first demonstration year or as specified in the Special Terms and Conditions of the waiver as approved by Federal CMS. Each annual evaluation report will detail the findings from to the above research questions and will include analysis of findings in the context of meeting program goals and objectives. After three years, the evaluation will include a summary report that summarizes the results from each of the three annual evaluation reports, provides a three-year trend analysis of program strengths and weaknesses and details findings in the context of meeting program goals and objectives over the three-year period.

After five years or at the end of the evaluation period whichever occurs later, the evaluation will include a final report that summarizes the results from each of the five annual evaluation reports and the three-year trend analysis report and provides a five-year trend analysis of program strengths and weaknesses. The final report will also detail findings in the context of meeting program goals and objectives over the five-year (i.e., complete waiver) period.

V. Waiver and Expenditure Authorities

The Agency is seeking authority through the proposed 1115 Research and Demonstration Waiver to implement the Medically Needy program as specified in Florida law. In order to meet the goals and objectives of the Medically Needy program, the state is seeking a waiver of the following Sections of the SSA is requested in accordance with Section 1115 of the SSA.

1. Section 1902(a)(14) insofar as it incorporates Section 1916, to permit the State to impose a premium.

2. Section 1902(a)(17) in order to impose a premium payment in a manner other than as provided in section 1903(f)(2)(B).

3. Section 1902(a)(10)(C) in order to provide eligibility (cover costs not otherwise matchable for this population).

In addition, the Agency requests costs not otherwise matchable for this population and expanded months of coverage that do not meet Florida Medicaid State Plan criteria.

VI. Public Process

The Agency will use several methods to solicit public input on the proposed 1115 Research and Demonstration Waiver for the proposed Medically Needy program including two publicly noticed workshops, posting the required Public Notice Document, consulting with the Federally Recognized Tribes of Florida and establishing the Medically Needy program website, as part of the Statewide Medicaid Managed Care (SMMC) program website, to solicit public input on the program. The public comments received will be used in the development of the waiver application for submission to Federal CMS. The following is a summary of the public process strategy to be used in the development of the waiver application is scheduled to begin in October 2012 and with submission of the application to Federal CMS in November 2012.

1. The Agency will consult with Florida's two federally recognized tribes, the Seminole Tribe and Miccosukee Tribe, through written correspondence to solicit input on the proposed Medically Needy program. This activity will be accomplished 30 days prior to submitting the initial waiver request to Federal CMS.

2. The Agency will publish the public meeting notices in the Florida Administrative Register[2] for the two public workshops to be held on separate dates in different areas of the state in October 2012.

3. The Agency will launch the proposed Medically Needy waiver application webpage in a readily identifiable way on the Agency's SMMC website in October 2012. The SMMC website is prominently located on the main webpage of the Agency's website. The following information will be made available on the proposed Medically Needy waiver application webpage:

   - A link to the Public Notice Document for the proposed Medically Needy waiver application,
   - Public meeting schedules,
   - A place for the interested stakeholders to post and review comments by the public,
   - Public meeting agendas and presentation materials,
   - Instructions on where to submit public comments via e-mail or mail,
   - A link to the relevant demonstration page(s) located on the Federal CMS website and
   - All future Medically Needy program information.

   The Agency website will provide a link to the Federal CMS website as required by Subpart G of Part 431, CFR. All interested stakeholders will be able to provide and review comments by the public for a minimum of 30 days prior to the submission of the waiver application to the Federal CMS.

4. The Agency will hold two public workshops on separate dates and in different areas of the state in October 2012 at least 30 days prior to submitting the waiver application. The public workshops will be held to solicit verbal and written comments from all interested stakeholders. The Agency will also announce at the workshops and on the Agency website that public input can be provided at any time via e-mail or postal mail.

[2] The Florida Administrative Weekly was renamed the Florida Administrative Register by the 2012 Florida Legislature effective October 1, 2012.

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