MANAGED MEDICAL ASSISTANCE SECTION 1115
DEMONSTRATION
WAIVER AUTHORITIES

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

TITLE: **Managed Medical Assistance Program**

AWARDEE: **Agency for Health Care Administration**

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

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act ("the Act") to enable the state to continue its Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled "Medicaid Reform") consistent with the approved Special Terms and Conditions (STC). The state has acknowledged that it has not asked for, nor has it received, a waiver of Section 1902(a)(2).

These waivers are effective beginning August 1, 2017 through June 30, 2022, unless otherwise specified.

Title XIX Waivers

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

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

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

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits.

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

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

MANAGED MEDICAL ASSISTANCE SECTION 1115
DEMONSTRATION
EXPENDITURE AUTHORITIES

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

TITLE: **Managed Medical Assistance Program**

AWARDEE: **Agency for Health Care Administration**

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall be regarded as expenditures under the state's title XIX plan for the period of August 1, 2017 through June 30, 2022, unless otherwise specified.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration.

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

2. Expenditures made by the state for uncompensated care costs incurred by providers for health care services for the uninsured and/or underinsured.

3. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program.

4. Expenditures for services provided to individuals in the MEDS-AD Eligibility Group, as described in STC 18, effective January 1, 2018.

5. Expenditures for services provided to individuals in the AIDS CNOM Eligibility Group, as described in STC 19, effective January 1, 2018.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Managed Medical Assistance Program**

AWARDEE: **Agency for Health Care Administration**

I. PREFACE

The following are the Special Terms and Conditions (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 & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act ("the Act"), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable (CNOM) under section 1903 of the Act, 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 those set forth below and in the foregoing waivers and expenditure authorities. The effective date of the demonstration amendment is no earlier than the amendment approval date through June 30, 2022.

These STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

Florida's current 1115 demonstration allows the state to operate a capitated Medicaid managed care program. Under the demonstration, most Medicaid-eligibles are required to enroll in one of the managed care plans contracted with the State. Several populations may also voluntarily enroll in managed care through the MMA program. Applicants for Medicaid are given the opportunity to select a managed care plan prior to receiving a Florida Medicaid eligibility determination. If they do not choose a plan, they are auto-assigned into a managed care plan upon an affirmative eligibility determination and subsequently provided with information about their choice of plans with the auto-assignment. Managed care plans are able to provide customized benefits to their members that differ from, but are not less than, the state plan benefits—and participating Medicaid-eligibles have access to Healthy Behaviors Programs that provide incentives for healthy behaviors. The demonstration also establishes a Low Income Pool (LIP) to ensure continuing support for the safety net providers that furnish uncompensated care (UC) to the Medicaid, uninsured, and underinsured populations.[1]

The renewal allows the state to continue operating the MMA program while increasing the LIP to $1.5 billion annually. The renewal also removes historical information about implementation of the MMA program from the STCs and modifies the frequency of state-reported demonstration activities—based on the long-standing nature of the demonstration, the consistency in its operations, and the lack of significant issues or corrective actions needed. All reporting modifications continue to provide CMS and the public with the information necessary to effectively monitor and evaluate the MMA demonstration.

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 Healthcare Effectiveness Data and Information Set [HEDIS]

[1] For the "Comprehensive Program Description and Objectives," see Attachment B.

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.
- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low-income populations in the state by targeting LIP funding to reimburse UC costs for services provided to low-income uninsured patients at hospitals and federally qualified health care centers (FQHC) and rural health clinics (RHC) that are furnished through charity care programs that adhere to the Healthcare Financial Management Association (HFMA) principles.[2]

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.**

    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 (BN) agreement for the demonstration as necessary to comply with such

[2] Available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589

change. The modified agreement will be effective upon implementation of the change. The trend rates for the BN agreement are not subject to change under STC 90.

b. If mandated changes in the federal law, regulation, or policy require 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 affecting 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 may be 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, BN, 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. 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 STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

    a) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

    b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    c) An explanation of the public process used by the state consistent with the requirements of STC 15; and,

d) The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress 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.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

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 thirty (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 thirty (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 fourteen (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 431.416(g): CMS may expedite or waive the federal and state public notice requirements 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 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 as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. 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.

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, and/or contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

16. **Federal Financial Participation.** 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. **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 438.4. The certification shall be developed according to 42 CFR 438.5 and submitted pursuant to 42 CFR 438.7.

The state must maintain:

a. Policies to ensure an increased stability among capitated managed care plans and fee-for-service (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.

b. Requirements contained herein are intended to be consistent with and not additional to the requirements of 42 CFR Part 438. The state must also maintain 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.

c. The state must ensure that each managed care entity calculates and reports a Medical Loss Ratio (MLR) for each contract and rating year. Such MLR calculation and reporting must be consistent with the standards specified in 42 CFR 438.8.

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

   1. For plans with a MLR above 95 percent, the state shall report any concerns about the plans' financial viability, plan performance, and continuation with the MMA program.

   2. For plans with a MLR below 75 percent, 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, consistent with 42 CFR 438.52.

f. Policies that result in a network of appropriate dental providers sufficient to provide adequate access to all covered dental services, consistent with 42 CFR 438.206 and 438.207.

IV. ELIGIBILITY DERIVED FROM THE DEMONSTRATION

This section governs the state's exercise of the expenditure authorities 4 and 5 listed on page 2 of these STCs. These groups derive their eligibility by virtue of the expenditure authorities expressly granted in this demonstration—eligibility and coverage for these groups are subject to Medicaid laws, regulations and policies, except as expressly identified as not applicable under expenditure authority granted herein.

18. MEDS AD Eligibility Group. The MEDS AD eligibility group consists of individuals who are not otherwise eligible for Medicaid benefits and who meet the following qualifying criteria:

a. Aged or disabled individuals
   1. Income at or below 88 percent FPL
   2. Assets that do not exceed $5,000 (individual) or $6,000 (couple)
   3. Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services

b. Aged or disabled individuals
   1. Income at or below 88 percent FPL
   2. Assets that do not exceed $5,000 (individual) or $6,000 (couple)
   3. Medicaid-only eligibles receiving hospice, HCBS, or institutional care services

c. Aged or disabled individuals
   1. Income at or below 88 percent FPL
   2. Assets that do not exceed $5,000 (individual) or $6,000 (couple)
   3. Medicare Eligible receiving hospice, HCBS, or institutional care services

19. AIDS CNOM Eligibility Group. The AIDS CNOM eligibility group consists of individuals who are not otherwise eligible for Medicaid benefits and who meet the following qualifying criteria:

a. Have a diagnosis of Acquired Immune Deficiency Syndrome (AIDS); and
b. Have an income at or below 222 percent of the federal poverty level (or 300% of the federal benefit rate);
c. Have assets that do not exceed $2,000 (individual) or $3,000 (couple); and
d. Meet hospital level of care, as determined by the State of Florida.

V. ENROLLMENT FOR THE MANAGED MEDICAL ASSISTANCE PROGRAM

20. 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.

21. Enrollment in Managed Care Under the MMA Program. MMA program enrollees are individuals eligible under the approved state plan, and who are described below as "mandatory enrollees" or as "voluntary enrollees." Mandatory enrollees are required to enroll in a managed care plan as a condition of receipt of Medicaid benefits. Voluntary enrollees are exempt from mandatory enrollment, but have the option to enroll in a demonstration managed care plan to receive Medicaid benefits.

a. Mandatory Managed Care Enrollees – Individuals who belong to the categories of Medicaid-eligibles listed in the following table, and who are not listed as excluded from mandatory participation, are required to be MMA program enrollees.

Table 1. Mandatory and Optional State Plan Eligibility Groups

Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Infants under age 1	No more than 206% of the FPL.	Title XIX	TANF & Related Grp
Children 1-5	No more than 140% of the FPL.	Title XIX	TANF & Related Grp
Children 6-18	No more than 133% of the FPL.	Title XIX	TANF & Related Grp
Blind/Disabled Children	Children eligible under Supplemental Security Income (SSI) or deemed to be receiving SSI.	Title XIX	Aged/Disabled
IV-E Foster Care and Adoption Subsidy	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	Income not exceeding 191% of FPL.	Title XIX	TANF & Related Grp
Section 1931 parents or other caretaker relatives	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	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA).	Title XIX	Aged/Disabled
Former foster care children up to age 26	Individuals who are under age 26 and who were in foster care and receiving Medicaid when they aged out.	Title XIX	TANF & Related Grp

Optional State Plan Groups			
State-funded Foster Care or Adoption assistance under age 18	Who receive a state Foster Care or adoption subsidy, not under title IV-E.	Title XIX	TANF & Related Grp
Individuals eligible under a hospice-related eligibility group	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236	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 STC 22(c).	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community-based waiver group specified at 42 CFR 435.217	This group includes non-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 STC 22(c).	Title XIX	Aged/Disabled
Demonstration Only Groups			
Aged or disabled individuals	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Aged or disabled individuals	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicaid-only eligibles receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Aged or disabled individuals	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicare Eligible receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Individuals diagnosed with AIDS	• Have an income at or below 222% of the federal poverty level (or 300% of the federal benefit rate), • Have assets that do not exceed $2,000 (individual) or $3,000 (couple), and • Meet hospital level of care, as determined by the State of Florida	Title XIX	AIDS CNOM

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 24.

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

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

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

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

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

    5. Children receiving services in a Prescribed Pediatric Extended Care (PPEC) facility; and

    6. 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.

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

    2. Family planning waiver eligibles;

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

    4. 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).

22. Indian Health Care Providers and Managed Care Protections.

a. The state will assure compliance by the state itself—and by any managed care entity under contract with the state for provision of Medicaid-covered services—with the requirements of section 1911 of the Social Security Act and 25 USC §1647a(a)(1), to accept an entity that is operated by the Indian Health Service (IHS) an Indian tribe, tribal organization, or urban Indian health program as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program, if the entity attests that it meets generally applicable State or other requirements for participation as a provider of health care services under the program.

b. The state will assure compliance by the state itself—and by any managed care entity under contract with the state for provision of Medicaid-covered services—with 42 CFR 431.110(b), which specifies that an IHS facility meeting state requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider, and also specifies that when state licensure is normally required, the facility need not obtain a license but must meet all applicable standards for licensure. In determining whether a facility meets these standards, the state may not take into account an absence of licensure of any staff member of the facility.

VI. ENROLLMENT

This section describes enrollment provisions that are applicable to Medicaid-eligible individuals.

23. New Enrollees. At the time of their application for Medicaid, individuals who are 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. Upon enrollment, individuals will receive information on their managed care plan assignment or selection and information about all plans in their area. Individuals may actively select a plan or change their plan selection 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, and how to access those benefits.

24. 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.

25. Auto Enrollment for Special Populations. For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to auto-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 auto-assigning recipients who are members of the indicated special populations 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 plan within the organization, then the beneficiary should be assigned as in sub-STCs 24 above.

b. If an applicable specialty plan is available, as described in STC 39, the recipient should be assigned to the specialty plan.

c. Newborns of eligible mothers enrolled in a plan at the time of the child's birth will be automatically enrolled in that plan, unless it is a specialty plan; however, the mother may choose another plan for the newborn within 120 days after the child's birth.

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

26. 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 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 and enroll in another managed care plan or receive their services through Florida FFS Medicaid.

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.

27. **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 managed care plan they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended due to plan requested or Agency-imposed enrollment freeze. The individual will have the same change/disenrollment period without cause as upon initial enrollment.

VII. BENEFIT PACKAGES AND PLANS IN THE MMA PROGRAM

28. **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 STCs 29 through 33, in accordance with section 409.973 F.S. 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 as defined by the plan and approved by the Agency for Health Care Administration (AHCA). These plans can also 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 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.

29. **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. Consistent with 42 CFR 438.3, 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.

30. **Plan Evaluation Tool.** The state will utilize a Plan Evaluation Tool (PET) to determine if a plan that is applying for, or has been awarded, an MMA plan contract meets state requirements. The PET measures 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 the sufficiency of benefits consistent with 42 CFR 438.210(a)(3) and STC 32. 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.

31. **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 Healthy Behaviors Program.

32. **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. 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 meet the needs of 98.5 percent of enrollees.

33. **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 given service 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.

VIII. COST-SHARING

34. 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.

35. American Indians. Indians who receive services directly by an Indian Health Care Provider (IHCP) or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premium, or similar charge. No deduction, copayment, cost sharing or similar charges shall be imposed against any such Indian. Payments due to an IHCP or to a health care provider through referral under Purchased/Referred Care services for services provided to an eligible Indian shall not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost sharing or similar charges, that would be due from the Indian but for the prohibition on charging the Indian.

IX. DELIVERY SYSTEMS

36. Health Plans. The final contracts developed to implement selective contracting by the state with any MCO, provider group, Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) shall be subject to CMS Regional Office approval prior to implementation. The following types of entities may contract with the state to offer managed care plans under this demonstration:

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 FS 409.912. A PSN may be reimbursed on a FFS or capitated basis as specified in state statute. Capitated PSNs are categorized as MCOs, and must meet the requirements as described in 42 CFR 438.

c. Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP)- Entities that meet the definition or PIHP or PAHP as described in 42 CFR 438.2 and which must conform to all requirements in 42.CFR 438 that apply to PIHPs and PAHPs.

37. Eligible Plan Selection. The state will procure a specified number of plans per region in accordance with section 409.974, Florida Statutes. A minimum and maximum number of plans are specified by region, with a minimum of two plans choices in each region. Issuance and award of the procurements will provide for a choice of plans, as well as market stability.

Should the state not be able contract with at least two plans in a region that is not rural, the state will issue another procurement to obtain a second plan and meet the federal

requirements in 42 CFR §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 39. 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 additional specialty plans in a region if total enrollment in all specialty plans in the region is greater than ten percent of demonstration enrollees in the 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 any 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.

38. Freedom of Choice. An enrollee's freedom of choice is limited to the providers in the plan's network. The state must provide demonstration enrollees access to the managed care delivery systems as necessary to meet the choice requirements as under 42 CFR 438.52.

a. Beneficiaries must also have a choice of at least two regional managed care plans in each region. While beneficiaries are encouraged to select the same MMA plan as their Medicare Advantage or Long-term Care (LTC) Plan, if applicable, it is not a requirement.

b. Should a beneficiary choose an MMA plan that is different from their Medicare Advantage or LTC plan, if applicable, the two entities must coordinate the beneficiaries care to ensure that all needs are met.

39. Specialty Plans. 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 target population, for example, children with chronic conditions, or recipients who have been diagnosed with 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 freeze enrollment for plans that meet the aforementioned enrollment limit. The Children's Medical Services Plan operated by the Florida Department of Health is not subject to competitive procurement.

The state may approve specialty plans on a case-by-case basis using criteria that include appropriateness of the target population and the presence of clinical programs and/or providers with special expertise to serve that target population in the specialty plan's provider network. The state may not approve plans that discriminate against members of the target population with greater health care needs.

The state may also contract with Medicare Advantage Organizations (MAO) to serve Medicare-Medicaid enrollees as a dual eligible special needs plan (D-SNP).

In addition to meeting the solvency (42 CFR 438.116) and network sufficiency (42 CFR 438.206 and 207) 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 include an integrated network of PCPs and specialists appropriate for the target population (e.g., nephrologists for kidney disease; cardiologists for cardiac disease; infectious disease specialists and immunologists for HIV/AIDS).

b. In recognition that many individuals will have multiple diagnoses, plans should have sufficient capacity of additional specialists to manage the co-occurring diagnoses that may occur within the target population.

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.

40. Requirements for Special Populations.

a. HIV Specialty Plans

1. 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.

2. 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.

3. 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.

4. 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.

5. 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

1. 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.

2. The Foster Care child's legal guardian may enroll the child in an MMA plan, or any specialty plan for which the child is eligible, that are available in the child's region.

3. 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 a Children's Specialty Plan available in the region.

41. Compliance with Medicaid and CHIP Managed Care Regulations. The state must comply with all Medicaid and CHIP managed care requirements set forth in 42 CFR Parts 431, 433, 438, 440, 457 and 495, including the Indian specific provisions at 42 CFR §438.14

unless waived or identified as not applicable in the waiver and expenditure authority documents, of which these STCs are a part. This includes:

a. **Definitions of Indians and Indian Health Care Provider** (**IHCP).** Indians and IHCPs are defined in 42 CFR §438.14(a).

b. **Access to IHCP.** Indians will be able to access covered benefits through the IHCP of their choice, regardless of whether the IHCP is a participating or non-participating provider.

c. **Referrals and Prior Authorization.** Managed care entities must permit nonparticipating IHCP to refer an Indian to a network provider without having to obtain a referral or a prior authorization from a participating provider.

d. **Access to Out of State IHCPs.** A managed care entity must allow Indian enrollees to access out-of-state IHCPs where timely access to covered services cannot be ensured because there are few or no IHCPs in the state.

e. **Disenrollment from Managed Care Entity.** Lack of access to in-network IHCP constitutes good cause for disenrollment from the managed care entity.

f. **Prompt Payment.** A managed care entity must make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.

g. **Payment Rates and Supplemental Payment.**

    1. **Non-FQHC.** An IHCP not enrolled in Medicaid as an FQHC, regardless of whether it participates in the network of an MCO, PIHP, PAHP and PCCM entity or not, has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.
    2. **FQHC.** An IHCP that is enrolled in Medicaid as an FQHC, but that is not a participating provider of the MCO, PIHP, PAHP or PCCM entity, must be paid an amount equal to the amount the MCO, PIHP, PAHP, or PCCM entity would pay an FQHC that is a network provider but is not an IHCP, including any supplemental payment from the state to make up the difference between the amount the MCO, PIHP, PAHP or PCCM entity pays and what the IHCP FQHC would have received under FFS.
    3. **Supplemental Payment.** The state must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, or PCCM entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

X. CONSUMER PROTECTIONS

42. Medical Care Advisory Committee. In accordance with 42 CFR §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 CFR §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. Beneficiary representation may include former Florida Medicaid recipients, current Florida Medicaid recipients or family members of former or current Florida Medicaid recipients who had direct experience with helping beneficiaries access Florida Medicaid eligibility, benefits, or services. 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.

a. **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. In addition, each advisory committee must provide input to the state on the consumer report cards, set forth in STC 112.

43. 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.

44. 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.

45. 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);

46. Operated Call Center Operations. The state must operate a call center(s) independent of the managed care 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 enable enrollees to voice complaints about each of the health plans independent of the health plans.

47. State Review of Beneficiary Complaints, Grievances and Appeals. 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 will continue to monitor these statistics throughout the demonstration period and report on them in the annual reports as specified in STC 73. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

XI. CHOICE COUNSELING

48. 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.

49. Choice Counseling Materials. Through the choice counselor the state offers an extensive enrollee education and plan 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 using the plan report card, and information about the plan report card will be provided to the recipients.

50. 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.

51. **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 enrollee communications, including written materials, spoken scripts and websites shall be at the fourth (4th)-grade comprehension 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.

52. **Contacting the Choice Counselor**. Individuals contact the state or the state's designated choice counselor to obtain additional information. Choice counseling and enrollment information is available at the AHCA's website or by phone. The state or the choice counselor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees. The state must ensure mechanisms are in place to monitor and evaluate choice counseling call center metrics and the individual performance of choice counseling personnel.

XII. HEALTHY BEHAVIORS PROGRAM UNDER THE MMA PROGRAM

53. **Healthy Behaviors Programs Under the MMA Program.** The state must require the managed care plans operating in the MMA program 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.

    a. The state must monitor to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and 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

54. MEDS AD Program. The MEDS AD program provides coverage for certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level (FPL). Individuals enrolled in the program receive all services offered through the state plan as well as the community-based services provided in the programs identified below which are operated by the state under the authority of 1915(c) of the Act.

a. Availability of the community-based services is subject to any numeric limitations on enrollment in such programs and the requirements that the individual meets the eligibility and level of care criteria for the services in these programs:

1. Program of All-inclusive Care for the Elderly (PACE)

2. Developmental Disabilities Individual Budget Home and Community Based Waiver

3. Model Waiver

4. Long-term Care Waiver.

55. AIDS Program. Recipients enrolled in the AIDS program will receive all services offered through the Florida Medicaid state plan. For beneficiaries transitioning from the 1915(c) PAC Waiver (0194.R05.00), there will be no loss of services.[3] In addition:

a. Recipients ages 21 years and older will continue to access all state plan services that are currently covered for adults and will be eligible to receive case management services through their health plan, medically necessary restorative massage, enteral formulas, and incontinence supplies not otherwise available to adult recipients. These incontinence supplies will be in addition to what is offered under the Medicaid state plan according to the parameters at 42 CFR 440.70—this includes a process whereby individuals can request items that are not on the state's pre-approved list but are coverable under the benefit.

b. Recipients under the age of 21 years will continue to have access to all state plan services and EPSDT benefits that are currently covered for children.

56. 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:

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[3] The majority of recipients that were enrolled in the 1915(c) PAC waiver received their medical, dental, behavioral health, and prescribed drug services from an MMA plan; therefore, there will be no change in how these individuals receive MMA services, unless they choose to change plans. There will be no change for recipients who are not enrolled in an MMA plan, and instead receive the aforementioned services through a Medicare Advantage Fully Liable D-SNP. This change will not affect how D-SNP enrollees receive their Medicare or Medicaid benefits.

a. **MomCare**: includes outreach and case management services for all women presumptively eligible and eligible for Medicaid under SOBRA. The MomCare component is a mandatory benefit 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.

57. 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.

g. Bereavement and volunteer services are provided but are not reimbursable services.

58. 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 FFS system or a managed care plan are required to obtain pharmaceutical services and products related to factor replacement therapy from one of the up to three contracted vendors. In addition to product distribution, the program provides pharmacy benefit management, direct beneficiary contact, personalized education, enhanced monitoring, and direct support of beneficiaries in the event of hospitalization, at no additional cost to the state. Enrollees have access to a registered nurse and licensed pharmacist 24 hours a day, seven days a week. The enrollees also have access to medical care and treatment through their usual and customary networks, with no restrictions on services or providers, and receive pharmacy products other than those related to factor replacement therapy via the usual and customary networks without restriction, as well.

The populations enrolled in the program have a diagnosis of hemophilia, are currently Medicaid eligible, receive prescribed drugs from the therapeutic MOF Factor IX, and MOE-Antihemophilic Factors, Corifact (MOC therapeutic class), Stimate (P2B therapeutic class), and other therapeutic classes identified by the Agency as treatment for hemophilia or von Willebrand. Medicaid-Medicare eligible individuals may voluntarily enroll in the program.

XIV. LOW INCOME POOL

59. Low Income Pool Definition. The LIP provides government support for safety net providers for the costs of uncompensated charity care for low-income individuals who are uninsured. Uncompensated care (UC) includes charity care for the uninsured but does not include UC for insured individuals, "bad debt," or Medicaid and CHIP shortfall. The resulting total computable (TC) dollar limit is enumerated in STC 61(a).

60. Availability of Low Income Pool Funds. The following STC presents the TC dollar limit for LIP spending for the current approval period, DY 12 through 16, subject to the assurances that follow.

a. **Total LIP Amount.** The TC dollar limit for LIP expenditures in each DY will be $1,508,385,773.

b. **Assurance.** As reflected in the LIP participation requirements in STC 69, the state and providers that are participating in LIP will provide assurance that LIP claims include only costs associated with UC that is furnished through a charity care program and that adheres to the principles of the HFMA operated by the provider.

61. Capped Annual Allotments. All annual LIP funds must be expended by September 30 following each authorized DY. Any amount not expended cannot be rolled over to the next DY. Capped annual allotment amounts that are not distributed because of penalties, recoupment due to payments exceeding UC cost, or are otherwise due to violating the terms of the approved STCs cannot be rolled over to another DY and are not recoverable.

62. LIP Reimbursement and Funding Methodology. The Reimbursement and Funding Methodology Document (RFMD) is prepared by the state for approval by CMS and documents LIP permissible expenditures, including the non-federal share and TC expenditures. The RFMD provides that TC LIP payments to providers for UC costs must be supported by UC 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 UC as charity care are limited to the uncompensated portion of providers' allowable costs and, in the aggregate, the authorized LIP pool amount for the DY.

a. Prior to August 1, 2017, the state must submit a draft of the DY 12 RFMD to CMS for approval–and CMS will work with Florida towards an approval by September 30, 2017. The state may not claim FFP for LIP payments in DY 12 until after the RFMD is approved by CMS.

1. Beginning in DY 13, in the event the RFMD methodology remains unaltered from the previous DY, the state will submit an attestation attached to the previous DY's RFMD stating that "the methodology contained herein remains in effect for the current DY XX," where XX represents the relevant DY.
2. Beginning in DY 13, in the event the RFMD's methodology is altered from the previous DY, in part or in whole, the state will follow the initial RFMD submission process outlined for DY 12 (see STC 68) RFMDs and/or attestations will be due for each DY to CMS on July 31 and, like all deliverables, should be submitted through the PMDA Portal.[4]

b. For each DY, the state must reconcile LIP payments made to providers to ensure that they do not exceed allowed UC costs, using the CMS approved RFMD cost review protocol. The state must submit a LIP Cost Reconciliation report to CMS within three 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 UC costs, the federal portion of any excess payment must be

[4] Available at https://portal.cms.gov/wps/portal/unauthportal/home/.

returned to CMS by submitting a decreasing expenditure adjustment (on Form CMS-64, 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 the DY for which the LIP Cost Reconciliation Report is overdue.

c. A provider may at any time during a DY disclose to the state that LIP payments to that provider exceeded allowed UC costs. If a provider refunds an overpayment to the state, the state must report that refund by including a decreasing expenditure adjustment on Line 10B of the CMS-64 for the quarter that it was received. If the provider reports an overpayment and does not refund that overpayment, the state has one year from the date of discovery, to have the provider refund the overpayment on the CMS-64. If the provider does not refund that overpayment within one year from the date of discovery, the state must refund the overpayment on the CMS-64. Any overpayments that have not been refunded to CMS may be subject to interest as defined under 42 CFR 433.320(a)(4).

d. A provider is not eligible for an LIP payment or continued LIP payments if (i) the provider is identified in a disallowance notice from CMS to the State as having received an LIP overpayment in a specified amount in a prior year; and (ii) the provider has not entered into a repayment agreement satisfactory to the State within 30 days after the date by which the State must credit CMS with the federal share of the specified overpayment, or (iii) the provider is in breach of a repayment agreement. A provider that is ineligible for LIP payments on the basis of the above may re-establish eligibility by making repayment arrangements satisfactory to the state.

e. Payments from LIP to hospitals are to be considered Medicaid hospital revenue for the purpose of determining the hospital-specific disproportionate share hospital **(**DSH) limits defined in section 1923(g) of the Act.

f. For the purposes of this STC, allowed UC cost follows the definitions described in STC 64 below.

63. 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. 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 who are uninsured. The costs must be incurred pursuant to a charity care program that adheres to the principles of the HFMA.

1. Providers may be categorized in up to three groups: hospitals, Medical School Physician Practices, and FQHCs/RHCs. Each group may be divided into up to five tiered subgroups, any of which may be based on ownership, UC Ratio, or ownership and UC Ratio. UC Ratio is defined as the amount of a provider's uncompensated

uninsured charity care costs (defined in (a) above), expressed as a percentage of its privately insured patient care costs. To define subgroups by UC Ratio, providers must be ranked based on their relative UC Ratios, and may be formed into subgroups based on contiguous ranges of UC Ratios. Hospital ownership subgroups may consist of one or more of the following categories: local government, state government, or private and may be grouped by the hospital's publically owned, statutory teaching, and freestanding children's hospital status. For each DY, up to $50,000,000 of the capped annual allotment of the LIP may be apportioned to FQHCs/RHCs.

2. All providers that must receive some amount of payment (following (1) above) must be paid the same percentage of their charity care cost within each subgroup.

3. Within each group and ownership subgroup, providers in tiers with a lower range of UC Ratios cannot be paid a greater share of their charity care cost than providers in tiers with higher UC Ratios.

4. Determination of (1) through (3) may be effectuated using hospital-specific cost data for the DY for which payments are being allocated, or for a prior year not more than three years prior to that DY.

64. Low Income Pool Permissible Hospital Expenditures. Hospital cost expenditures from the LIP will be paid up to cost and are further defined in the RFMD utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs that will be defined in the RFMD. The state shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.

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

66. 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 as sources of non-federal funding.

XV. LOW INCOME POOL PROVIDER PARTICIPATION REQUIREMENTS AND DELIVERABLES

67. Aggregate LIP Funding. Up to $1,508,385,773 in LIP funds will be available to the state each DY. That amount will be reduced by any penalties that are assessed by CMS pursuant to STC 62 and/or reconciliation overpayments as discussed in STC 63. Provider Participation requirements, described in STC 69 must be met for the state to draw and providers to be paid from the annual LIP funds for payment to providers.

69. LIP Provider Participation Requirements. Hospitals, Medical School Physician Practices, and FQHCs/RHCs must meet the participation requirements set forth in this STC to be eligible to receive LIP funds. Th**e** state may grant an exemption to a hospital with respect to the requirement in (a)(2) below, upon finding that the hospital has demonstrated that it was refused a contract despite a good faith negotiation with a Specialty Plan**.** A letter from a Specialty Plan declining to enter a contract, or some other comparable evidence, will be required to make such a finding. The state may grant an exemption to an FQHC/RHC with respect to the requirement in (c)(1) below, upon finding that the FQHC/RHC has demonstrated that it was refused a contract despite a good faith negotiation with a Standard Plan. A letter from a Standard Plan declining to enter a contract, or some other comparable evidence, will be required to make such a finding.

a. **Hospitals.**

1. Must contract with at least fifty percent of the Standard Plan MCOs in their corresponding region

2. Must contract with at least one Specialty Plan for each target population that is served by a specialty plan in their corresponding region

3. Must participate in the Florida Event Notification System[5] program, except that participation is voluntary for hospitals with 25 or fewer beds.

4. The state and participating providers will provide assurance that LIP claims include only costs associated with UC furnished through a charity care program and that adheres to the principles of the HFMA and is operated by the provider**.**

5. 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**

1. Must participate in the Florida Medical Schools Quality Network

2. The state and participating providers will provide assurance that LIP claims include only costs associated with UC through the provider's charity care program and that adheres to the principles of the HFMA.

[5] Available at https://www.florida-hie.net/ens/index.html.

3. Participating providers must be enrolled Medicaid providers and have a minimum of 1 percent Medicaid utilization. The state will review data submitted by the participating providers to determine the percentage of Medicaid utilization.

c. **Federally Qualified Health Centers and Rural Health Clinics**

1. Must contract with at least 50 percent of Standard Plan MCOs in their corresponding region.

2. Must be enrolled in Medicaid.

68. Deliverable Requirements. By June 1 of each year, the state must submit to CMS a report detailing for the upcoming demonstration year, the projected LIP providers, the estimated per provider amount of uncompensated care to be furnished through charity care, and the estimated IGTs associated with each provider. By October 1 of each year, for the demonstration year just ended, the state must submit to CMS the final report of the LIP providers, final 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.

XVI. GENERAL REPORTING REQUIREMENTS

69. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

70. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

71. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they shall make such data available for the

federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in paragraph 77.

72. Cooperation with Federal Learning Collaboration Efforts. The state will cooperate with improvement and learning collaboration efforts by CMS.

73. Annual Monitoring Reports. The state must submit one (1) compiled Annual Report each DY. The compiled Annual Report is due no later than ninety (90) days following the end of the DY. The state shall also submit semi-annual report(s) *at the request* of CMS. If semi-annual reports are requested, the state will have ninety (90) days to submit following the CMS request. In addition, CMS reserves the right to increase the frequency of reporting as deemed necessary by CMS Officials (e.g., to require quarterly reports).

a. The Annual Reports shall provide sufficient information for CMS to understand implementation progress of the demonstration including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements and should not direct readers to links outside the report. (Additional links not referenced in the document may be listed in a Reference/Bibliography section).

b. The Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

1. Operational Updates - The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.

2. Performance Metrics –Any required monitoring and performance metrics must be included in writing in the Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.

3. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated BN workbook with every Annual Report that meets all the reporting requirements for monitoring BN set forth in the General Financial Requirements section of these STCs, including the submission of corrected BN data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

4. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends for monitoring and evaluation of the demonstration.

74. Additional Demonstration Annual Operational Report Requirements. Annual Report must, at a minimum, include the requirements outlined below:

a. Items included must be summarized to reflect the operation/activities throughout the DY;

b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

c. Total contributions, withdrawals, balances, and credits; and

d. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the BN agreement.

75. Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. CMS will provide updates 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 will jointly develop the agenda for the calls. Areas to be addressed during the monitoring call may include, but are not limited to:

a. Transition and implementation activities;

b. Stakeholder concerns;

c. Operations and performance;

d. Enrollment;

e. Cost sharing;

f. Quality of care;

g. Beneficiary access;

h. Benefit package and wrap around benefits;

i. Audits;

j. Lawsuits;

k. Financial reporting and BN issues;

l. Progress on evaluation activities and contracts;

m. Related legislative developments in the state; and

n. Any demonstration changes or amendments the state is considering.

76. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (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 must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in its compiled Annual Report.

77. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS will issue deferrals in the amount of $5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

    1. CMS may decline the extension request.

    2. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

    3. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example what quarter the deferral applies to, and how the deferral is released.

XVII. GENERAL FINANCIAL REQUIREMENTS

78. 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 BN. 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.

79. 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 BN agreement. The following describes the reporting of expenditures subject to the BN 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 BN 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 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 BN limit. The waiver names designate the waiver forms in the MBES/CBES system to report Title XIX expenditures associated with the demonstration.

1. The CMS-64 will reflect the expenditures for statewide MMA populations, including those attributable to MMA mandatory and voluntary populations. The following Medicaid Eligibility Group (MEG) names and definitions will be utilized for CMS-64 reporting purposes:

   i. MEG 1: Aged and disabled demonstration enrollees. Waiver Name: "Aged/Disabled"

   ii. MEG 2: TANF demonstration enrollees. Waiver Name: "TANF & Related Group"

   iii. MEG 3: Low Income Pool expenditures. Waiver Name: "LIP"

   iv. MEG 4: MEDS AD demonstration enrollees. Waiver Name: "MEDS AD"

   v. MEG 5: AIDS demonstration enrollees. Waiver Name: "AIDS CNOM"

   vi. MEG 6: Healthy Start expenditures. Waiver Name: "Healthy Start CNOM"

   vii. MEG 7: PACC expenditures. Waiver Name: "PACC CNOM"

2. **Changes to AIDS Expenditure Reporting.** Beginning January 1, 2018, expenditures for the individuals described in STC 55 must be reported under MEG 5 on form CMS-64.9—and excluded from MEGs 1 and 2.

3. **Changes to Healthy Start & PACC Expenditure Reporting.** Beginning January 1, 2018, expenditures for the Healthy Start and PACC CNOMs must be reported under MEGs 6 and 7, respectively, on CMS-64.9 forms.

4. **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 (see STC 98).

e. Excluded Services. The following services are excluded from the demonstration, in that they are excluded from the list of benefits for which MMA managed care plans will provide coverage. Expenditures for these services are not expenditures subject to the BN limit, so should not be reported on any Forms CMS-64.9 Waiver and/or 64.9P Waiver for this demonstration.

1. Home and Community Based Service Waiver Services (Model Waiver (formerly Katie Beckett Model Waiver Services), Familial Dysautonomia, Development Disabilities Individual Budgeting);
2. Long Term Care Waiver;
3. ICF/IID Institutional Services;
4. School Based Administrative Claiming;
5. 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;
6. Medical foster care services;
7. Prescribed pediatric extended care (PPEC) services;
8. County matching programs (Substance Abuse and Medicaid Certified School Match Services);
9. State Mental Health Hospital services for recipients age 65 and older;
10. Certain physician-injectable procedures;
11. Vaccines for Children program for MediKids; and
12. Early Intervention Services.

f. Cost-Sharing Adjustments. Applicable cost-sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both TC and federal share) should also be reported separately by DY on Form CMS-64 Narrative. In the calculation of expenditures subject to the BN expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

g. Administrative Costs. Administrative costs will not be included in the BN 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".

h. Claiming Period. All claims for expenditures subject to the BN 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 BN.

i. Sanctions and Liquidated Damages. If the state imposes monetary sanctions or liquidated damages against an MCO, the state must report the monetary amounts on the CMS-64 Summary Line 9D in the quarter in which the plan has exhausted all administrative appeals or the time to seek an administrative appeal has expired.

j. Expenditures Subject to the Budget Neutrality Limits. The following types of expenditures are subject to the BN limits for this demonstration.

1. All medical assistance expenditures for Medicaid beneficiaries in the categories listed in STC 21(a), (b), or (c) (regardless of their managed care enrollment status), other than expenditures for services listed in STC 79(e),

2. All expenditures made under section 1115(a)(2) expenditure authority, including all payments made under LIP, through June 30, 2022.

80. Reporting Member Months. The following describes the reporting of member months for demonstration populations.

a. For the purpose of calculating the BN expenditure limit and for other purposes, the state must provide to CMS, as part of the Budget Neutrality Monitoring Tool required under STC 98, the actual number of eligible member months for the MEGs described in subparagraph (d) below. The state must submit a statement accompanying the Budget Neutrality Monitoring Tool, 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. The state must report 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 sub-STC (d)(i) above.

d. The state must report member months for MEGs 1, 2 and 4.

81. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (TC and federal share) subject to the BN 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.

82. 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 XVII:

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 carve-out services and for voluntary MMA populations that choose to stay in FFS;

d. Net Expenditures associated with the LIP, as described in Section XIV; 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.

83. 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.

84. 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.

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

86. 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 BN 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. STCs 87 and 88 specify the two independent financial caps on the amount of federal Title XIX funding that the state may receive on expenditures subject to the BN limit as defined in STC 79. 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.

87. Budget Neutrality Limit for the LIP. The maximum allowable LIP amount is capped annually at $1,508,385,773 (TC). LIP funds not distributed in a DY cannot be rolled over to the next. The federal share of the TC LIP amount is the maximum amount of FFP that the state may receive for the LIP permissible expenditures detailed in STC 64(a). For each DY, the federal share will be calculated using the FMAP rate(s) applicable to that year.

88. 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 STC 79 during the approval period of the demonstration. The limit is determined using a PMPM method. The BN targets are set on a yearly basis with a cumulative BN limit for the length of the entire demonstration (see STC92, Table 2). 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 BN limit. CMS' assessment of the state's compliance with these limits will be done using the CMS-64 Report from the MBES/CBES System.

89. Risk. The state shall be at risk for the per capita cost of demonstration enrollees under this BN agreement, but not for the number of demonstration enrollees. Providing FFP for all demonstration enrollees ensures that the state will not be put at risk solely due to changing economic conditions that 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.

90. Budget Neutrality Expenditure Limit. The following describes the method for calculating the BN expenditure limit for the demonstration. Demonstration expenditures shall be reported under the Medicaid Eligibility Groups (MEG) listed in STC 79(d). For the purpose of calculating the overall PMPM expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a DY basis. The annual estimates will then be summed 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 for the types of Medicaid expenditures described in this section. Budget neutrality calculations for both "With Waiver" (WW) and "Without Waiver" (WOW) expenditures are applied on a statewide basis. The federal share of the BN limit will be the total computable BN limit times Composite Federal Share (described below). For the purpose of monitoring BN, the annual LIP expenditures enumerated in STC 61(a) shall be considered as both WW and WOW expenditures (i.e. pass through costs).

a. Projecting Service Expenditures - Each yearly estimate of MMA service expenditures will be the cost projections for the MEGs in sub-STC (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 STC 80.

   Specifically,

   1. "Aged/Disabled" MEG PMPM is multiplied by MEG 1 member months
   2. "TANF & Rel Grp" MEG PMPM is multiplied by MEG 2 member months

b. Projected PMPM Cost - The PMPM costs for each MEG used to calculate the annual BN expenditure limit for this demonstration is specified below in Table 2.

   Table 2. PMPM Costs by MEG and Demonstration Year

	Aged/Disabled MEG 1	**Trend Rate**	**TANF & Rel Grp MEG 2**	**Trend Rate**
DY12	$1,027.49	4.0%	$267.77	4.6%
DY13	$1,068.59	4.0%	$280.09	4.6%
DY14	$1,111.33	4.0%	$292.97	4.6%
DY15	$1,155.78	4.0%	$306.45	4.6%
DY16	$1,202.01	4.0%	$320.55	4.6%

91. How the Limit will be Applied. The limits as defined in STCs 87 through 90 will apply to the actual expenditures for the demonstration, as reported by the state under Section XVIII, and specifically, to expenditures reported for the following MEGs: MEG 1 and MEG 2. If at the end of the demonstration period the BN 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.

92. Hypotheticals & Supplemental Budget Neutrality Tests. Optional demonstration expenditures that *could have been* covered via the Medicaid state plan, but instead are provided through section 1115(a) expenditure authority, may be designated as "hypotheticals" for the purposes of BN. In these cases, CMS may allow adjustment(s) to the WOW baseline to hold states harmless for the spending which it could have hypothetically provided through the Medicaid state plan. Separate WOW limits are provided below for the

costs associated with this demonstration's hypothetical expenditures and, if the limits are exceeded, that excess spending must be "paid for" with overall BN savings.

a. The MEDS AD MEG listed in Table 3 below is included in this demonstration's Supplemental Budget Neutrality Test.

Table 3. PMPMs for Supplemental BN Test

	Trend	**DY12**	**DY13**	**DY14**	**DY15**	**DY16**
MEDS AD PMPM	0.00%	$1,004.22	$1,004.22	$1,004.22	$1,004.22	$1,004.22

b. The MEDS AD expenditures cap for the supplemental BN test is calculated by multiplying the projected PMPM for the MEDS AD MEG, each DY, by the number of actual eligible MEDS AD member months for the same/corresponding MEG/DY—and summing the products together across all DYs. The federal share of the MEDS AD expenditure cap is obtained by multiplying this cap by the Composite Federal Share described in STC 95 below.

c. If the actual FFP claimed by the state for the MEDS AD MEG for all DYs is greater than the federal share of the MEDS AD expenditure cap defined in sub-STC (b) above, then that overage will be subtracted from the demonstration's overall BN variance.

93. Savings Phase-Out. Each DY, the net variance between the WOW cost and actual WW cost will be reduced for selected population-based MEGs. The reduced variance, to be calculated as a percentage of the total variance, will supersede the total variance in determining overall BN for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the WOW cost estimate.) The formula for calculating the reduced variance is: reduced variance equals total variance multiplied by the applicable percentage. The applicable percentages for each MEG and DY are determined based upon length of time the associated population has been enrolled in managed care; lower percentages are associated with longer established managed care populations. The MEGs affected by this provision and the applicable percentages are shown in Table 4 below, except that if the total variance for a MEG in a DY is negative, the applicable percentage is 100 percent.

Table 4. Savings Phase-Out Percentages

	DY 12	DY 13	DY 14	DY 15	DY 16
MEG 1 and MEG 2	66%	60%	55%	49%	44%

94. Impermissible DSH, Taxes or Donations. CMS reserves the right to adjust the BN 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 BN 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.

95. Composite Federal Share Ratio. The federal share of the BN expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C, with consideration of allowable demonstration offsets such as premium collections, by TC demonstration expenditures for the same period as reported on the same forms. Composite Federal Share is determined by applying the above calculation to expenditures reported under MEG 1 and MEG 2 combined. For the purpose of interim monitoring of BN, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

96. Enforcement of Budget Neutrality. CMS shall enforce BN over the life of the demonstration extension, which will be from August 1, 2017 through June 30, 2022. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration periods comprising DY 7 through 11 (but not from any earlier approval period).. However, no later than 6 months after the end of each DY, the state will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in STC 74. This amount will be compared with the actual FFP claimed by the state under BN. Using the schedule in Table 5 below as a guide for the PCCM budget limit, if the state exceeds the cumulative BN expenditure limit, they shall submit a corrective action plan to CMS for approval. The state will subsequently implement the approved program.

Table 5. Maximum Budget Neutrality Caps

Demonstration Year	Cumulative Target Definition	Percentage
DY12	Cumulative BN Limit Plus:	2.0 percent
DY12 through DY13	Cumulative BN Limit Plus:	1.5 percent
DY13 through DY14	Cumulative BN Limit Plus:	1.0 percent
DY14 through DY15	Cumulative BN Limit Plus:	0.5 percent
DY15 through DY16	Cumulative BN Limit Plus:	0.0 percent

97. Annual Budget Neutrality Report. On or before June 30, 2018, and on or before June 30 of each year thereafter, the state shall submit to CMS an Annual BN Monitoring Report, which will include an assessment of the demonstration's BN status based on actual expenditures to-date (including complete or nearly complete actual expenditures for the immediately preceding DY), the cumulative BN limit to-date, and updated projections for both the BN limit and WW expenditures through the end of the current approval period. If

the state's actual expenditures are found to have exceeded the cumulative BN limit by more than the percentages described in Table 5 above, or if the state's projections indicate that that actual cumulative spending are likely to exceed the BN limit for the approval period, the state must include corrective actions to ensure BN for the demonstration.

98. Budget Neutrality Monitoring Tool. The state will provide CMS with quarterly BN status updates via the reporting of demonstration expenditures in the BN Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool will be jointly developed with the state and incorporate the "Schedule C Report" for comparing demonstration's actual expenditures to the caps which are subject to BN expenditure limits described in STC 90.. CMS will provide technical assistance, upon request.

99. Exceeding Budget Neutrality. If the BN expenditure limit has been exceeded at the end of the demonstration period, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the BN agreement, the BN test shall be based on the time elapsed through the termination date.

XIX. EVALUATION OF THE DEMONSTRATION

100. Independent Evaluator. At the beginning of the demonstration period, the state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft Evaluation Design. For scientific integrity, every effort should be made to follow the approved methodology. State evaluations must follow the approved methodology, however, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

101. Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

102. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment B of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.

103. Evaluation Design Approval and Updates. The state's draft Evaluation Design may be subject to multiple revisions until a format and the content is agreed upon by CMS. The state

must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs.

104. Evaluation Questions and Hypotheses. Consistent with Attachments B & C of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each waiver and expenditure authority should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

105. State Must Separately Evaluate Components of the Demonstration. The outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the state met the demonstration goal, with recommendations for future efforts regarding all components.

a. At a minimum, the draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those outlined in subparagraphs (b). The draft design will discuss:

    1. The outcome measures to be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population;

    2. The data sources and sampling methodology for assessing these outcomes; and

    3. A detailed analysis plan that describes how the effects of the demonstration are isolated from other initiatives occurring in the state.

b. The evaluation must outline and address evaluation questions for all of the following components:

    1. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;

    2. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;

    3. Participation in the Healthy Behaviors programs and its effect on participant behavior or health status;

    4. The impact of LIP funding on hospital charity care programs;

5. 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;
6. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals; and
7. The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner.

106. Interim Evaluation Report. Following approval from CMS on the Evaluation Design**,** the state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment C of these STCs.

107. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment C of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period by December 31, 2023 (i.e., within 18 months of the end of the approval period represented by these STCs). The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

108. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, post approval, in conjunction with these STCs. The state shall present on its interim and summative evaluation in conjunction with these STCs. Presentation may be conducted remotely.

109. Public Access. The State must post all final reports submitted to CMS for approval on the state's Medicaid website within 30 days of approval by CMS.

110. Additional Publications and Presentations. For a period of twenty-four (24) months following CMS approval of the final reports, CMS will be notified prior presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

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

111. External Quality Review (EQR). The state is required to meet all requirements for external quality review (EQR) found in 42 CFR 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.

112. 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 managed care 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 plan. The report cards must also address the performance of subcontracted dental plans.

113. Performance Improvement Projects (PIP). The state must require each managed care 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. Specialty plans that do not have sufficient numbers of eligible recipients for the PIP topics identified in 111(a) or 111(b) may conduct alternative PIPs on topics more relevant to their enrolled population in place of the required focus areas, subject to approval by the state.

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:

    1. Population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that have been identified as in need of improvement;

    2. Integrating primary care and behavioral health; and

    3. Reducing preventable readmissions.

Each PIP must be conducted in accordance with 42 CFR §438.330 and 438.340.

The state must incorporate these PIP requirements into its MMA managed care plan contracts upon implementation of the MMA program.

114. Measurement Activities. The state must ensure that each participating managed care 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. In addition to requirements set forth at 42 CFR §§ 438.330 and 438.334, 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.

XXI. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
90 days following the end of the DY	Annual Report	Section XVI, STC 73
30 days following the end of the quarter	Quarterly Expenditure Reports	Section XVII, STC 78
November 30, Annually	LIP Draft RFMD and/or Attestation	Section XIV, STC 62
Within 3 years of the end of each DY	LIP Cost Reconciliation Report	Section XIV, STC 62b
June 1, Annually	LIP Provider UC and IGT estimate report	Section XIV STC 68
October 1, Annually	LIP Provider, UC and IGT final report	Section XIV STC 68
Within 120 Days of the effective date of STCs	Draft Evaluation Design	Section XIX STC 102

ATTACHMENT A
COMPREHENSIVE 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 (TC) 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 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 were replaced by the plan's Healthy Behaviors program upon implementation of the MMA program as described in STC 53. 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 (TC).
- 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 UC costs of providers, the independent report discussed below, and other categories of expenditure as specified in the STCs.
- UC costs were required to be verified through provider cost reports. CMS indicated that it would disallow unallowable payments to providers in prior DYs 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 FFS 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 DY (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 added 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 (FS).
- The second amendment authorized 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 authorized 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 (TC). The total amount of LIP funding in DY 11 (July 1, 2016 – June 30, 2017) will not exceed $607,825,452 million (TC). The changes represent a transition to a LIP that reflects the cost to providers of UC 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.

On October 12, 2016, CMS approved three amendments which modified the demonstration to: (a) allow Florida flexibility to contract with one to three vendors under the hemophilia program; (b) include payments for nursing facility (NF) services in MMA capitation rates for recipients under the age of 18 years; and (c) allow flexibility for specialty plans to conduct Performance

Improvement Projects (PIP) on topics that have more specific impacts to their enrollees, with Florida approval.[6]

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 UC costs for services provided to low-income uninsured patients at hospitals that are furnished through charity care programs that adhere to the (HFMA) principles.[7]

On August 1, 2017, CMS reauthorized the MMA Medicaid managed care program for the 5-year extension without significant changes to the program. The revised STCs for the extension reflected the state's obligation to follow the Medicaid managed care regulations at 42 CFR 438, and CMS and Florida agreed to several revisions to the STCs that previously governed the state's LIP. The revised LIP calculations reflected in the extension STCs led to a new TC annual LIP limit of $1.5 billion per DY—which was an annual increase of approximately $900 million compared to the previous DY's LIP amount.

There were two changes which led to the increased annual LIP limit:

- CMS' analysis of more recent Florida hospital cost report data led to an increase of $450 million in annual LIP; and
- CMS did not apply the previous LIP reduction for Medicaid expansion which led to an additional increase of $450 million annually—this was the only significant change to CMS' previous methodology for determining UC amounts.

[6] For the "Comprehensive Program Description and Objectives," see Attachment B.
[7] http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589

Consistent with CMS' goal of lessening or removing unduly burdensome and/or duplicative state reporting requirements, where appropriate, the extension STCs also omitted the requirement for quarterly reporting on all MMA demonstration activities (although expenditures continue to be reported quarterly, and annual reporting is required, consistent with the statutory requirement of periodic state reports). In addition, the requirement for the state to submit the LIP Reimbursement and Funding Methodology (RFMD) document for CMS approval was limited to the first extension DY—with subsequent annual attestations that the methodology remains in effect. CMS also eliminated the requirement for a Comprehensive Quality Strategy in the extension; however, the state still is required to develop and maintain a managed care quality strategy as required under 42 CFR §438.340.

Historical PMPMs and Trend Rates

Demonstration Year	SSI MEG	Trend Rate	TANF MEG	Trend Rate
DY 1 (SFY 2006/7)	$948.79	8.0%	$199.48	8.0%
DY 2 (SFY 2007/8)	$1,024.69	8.0%	$215.44	8.0%
DY 3 (SFY 2008/9)	$1,106.67	8.0%	$232.68	8.0%
DY 4 (SFY 2009/10)	$1,195.20	8.0%	$251.29	8.0%
DY 5 (SFY 2010/11)	$1,290.82	8.0%	$271.39	8.0%
DY 6 (SFY 2011/12)	$1,356.65	5.1%	$285.77	5.3%
DY 7 (SFY 2012/13)	$1,425.84	5.1%	$300.92	5.3%
DY 8 (SFY 2013/14)	$1,498.56	5.1%	$316.87	5.3%
DY 9 (SFY 2014/15)	$786.70	4.1%	$324.13	4.6%
DY 10 (SFY 2015/16)	$830.22	4.1%	$339.04	4.6%
DY 11 (SFY 2016/17)	$876.81	4.1%	$354.64	4.6%

ATTACHMENT B
DEVELOPING THE EVALUATION DESIGN

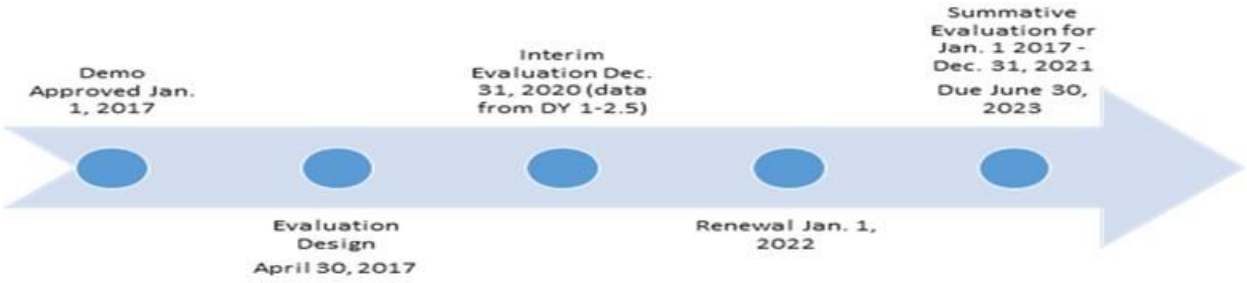
Introduction
For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
   a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
   b. Qualitative analysis methods may be used, and must be described in detail.
   c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
   d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
   e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
   f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (If the state proposes to do a survey as part of the evaluation, CMS will have 45 days from the date of submission to review the survey instrument for approval.

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
      b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid FFS and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1) When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or
   c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
   a. Operating smoothly without administrative changes; and
   b. No or minimal appeals and grievances; and
   c. No state issues with CMS 64 reporting or BN; and
   d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** The process the state will use for obtaining an independent entity to conduct the analysis and write the Evaluation Report, including a description of the qualifications the entity must possess. As soon as known, this section should be updated to include:
   a. Information about the organization conducting the evaluation;
   b. Contact information for the organization, including how to obtain a copy of the evaluation;
   c. The name and contact information of the Principal Investigator; and
   d. Curriculum Vitae of the Principal Investigator.

2) **No Conflict of Interest.** Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. This includes "No Conflict of Interest" signed conformation statements.

3) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to, the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

4) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT C
PREPARING THE EVALUATION REPORT

Introduction
For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports
Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment
Title XIX of the Social Security Act ("the Act") requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

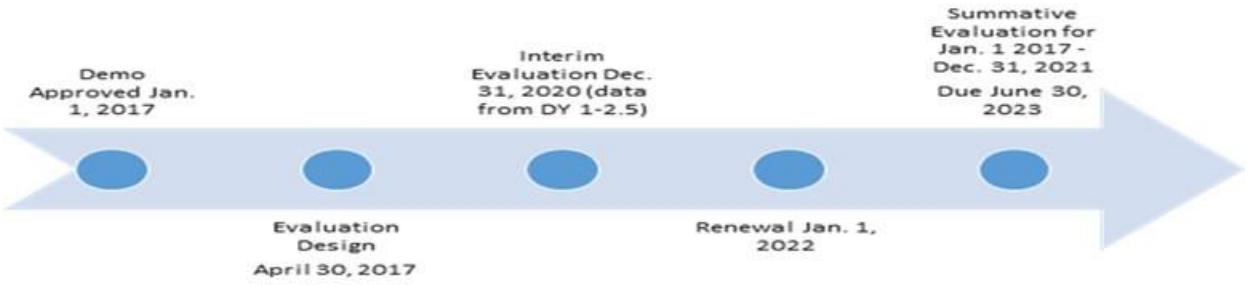
The format for the Interim and Summative Evaluation reports are as follows:

A. Executive Summary;
B. General Background Information;

C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

2) Identify the state's hypotheses about the outcomes of the demonstration:

    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period*—Describe the time periods for which data will be collected
4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?
2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design