GENERAL PROGRAM REQUIREMENTS

#59 1. **Managed Care Requirements**. The State must comply with the managed care regulations published at 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan services used in the rate development process.

The State must provide for the following:

a) Policies to ensure an increased stability among managed care organizations (MCO) and provider service networks (PSNs) and minimize plan turnover. This could include a limit on the number of participating plans in the five Demonstration counties. Plan selection and oversight criteria should include: confirmation that solvency requirements are being met; prior business operations in the State; and financial penalties for not completing a contract term. The State must report quarterly on the plans entering and leaving Demonstration counties, including the reasons for plans leaving. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension;

b) Requirements contained herein are intended to be consistent with and not additional to the requirements of 42 CFR 438. Policies to ensure network adequacy and access requirements which address travel time and distance, as well as the availability of routine, urgent and emergent appointments, and which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The State must implement a thorough and consistent oversight review for determining plan compliance with these requirements and report these findings to CMS on a quarterly basis. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension;

c) A requirement that each MCO and capitated PSN maintain an annual Medical Loss Ratio (MLR) of 85 percent for Medicaid operations in the Demonstration counties and provide documentation to the State and CMS to show ongoing compliance. The State must develop quarterly reporting of MLR during Demonstration year (DY) 6 specific to Demonstration counties. Beginning in DY 7 (July 1, 2012), plans must meet annual MLR requirements. CMS will determine the corrective action for non-compliance with this requirement;

d) Policies that provide for an improved transition and continuity of care when enrollees are required to change plans (e.g. transition of enrollees under case management and those with complex medication needs, and maintaining existing care relationships). Policies must also address beneficiary continuity and coordination of care when a physician leaves a health plan and requests by beneficiaries to seek out of network care. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension; and,

e) Policies to ensure adequate choice 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. The State must provide these policies to CMS within 90 days of the award of the Demonstration extension.

LOW INCOME POOL

#60

Low Income Pool Definition. The LIP ensures continued government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP consists of a capped annual allotment of $1 billion total computable for each year of the Demonstration extension.

#61

Availability of Low Income Pool Funds. Funds in the LIP are available to the State on an annual basis subject to any penalties that are assessed by CMS for the failure to meet milestones as discussed in Section XV "Low Income Pool Milestones". Funds not distributed in a DY may be rolled over to the next DY.

#62

LIP Reimbursement and Funding Methodology. LIP permissible expenditures defining State authorized expenditures from and entities eligible to receive LIP reimbursement are defined in the Reimbursement and Funding Methodology document dated June 26, 2009. This document limits LIP payments to allowable costs incurred by providers and requires the State to reconcile LIP payments to auditable costs. CMS is currently working with the State on reconciliations for DY 1, 2, and 3. Reconciliations for DY 4 and 5 are not yet available. CMS and the State will finalize DY 1, 2, and 3 reconciliations within 60 days of the acceptance of these STCs. Based on the outcomes of these initial reconciliations, CMS will either approve the existing Reimbursement and Funding Methodology during the renewal period (DYs 6-9) or will identify modifications to the Methodology to address any cost documentation or audit processes necessary to fully meet cost reconciliation requirements. Any changes required by CMS will be applied prospectively to audits not yet completed (DY6, DY7, and DY8). The State may claim LIP payments based on the existing Methodology for the 60 day reconciliation finalization period. Claims after that period can only be made on the Reimbursement and Funding Methodology approved in 2011 based on the reconciliation outcomes. Changes to the Reimbursement and Funding Methodology document requested by the State must be approved by CMS.

#63

Low Income Pool Permissible Expenditures. Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured. Medicaid shortfall (after all other title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS.

#64

Low Income Pool Expenditures - Non-Qualified Aliens. LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens.

#65 7. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-Federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in paragraph 62.

#66 8. **Low Income Pool Permissible Hospital Expenditures.** Hospital cost expenditures from the LIP will be paid at cost and are further defined in the Reimbursement and Funding Methodology document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost.

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

#68 10. **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.

LOW INCOME POOL MILESTONES

#69 11. **Aggregate LIP Funding.** At the beginning of each DY, $1 billion in LIP funds will be available to the State. These amounts will be reduced by any milestone penalties that are assessed by CMS. Two tiers of milestones, as described in paragraph's 70 and 71, must be met for the State and facilities to have access to 100 percent of the annual LIP funds. Funds not distributed in a DY may be rolled over to the next DY.

#70 12. **Tier - One Milestone.** Tier-one milestones are defined as follows:

a) Development and implementation of a State initiative that requires Florida to allocate $50 million annually in LIP funding to establish new, or significantly enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim.
   i. Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;

ii. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,
iii. Reducing per-capita costs.

Expenditures incurred under this program must be permissible LIP expenditures as defined under Section XIV, Low Income Pool. The State will utilize DY 6 (7/1/2011 – 6/30/2012) to develop the program. The program must be implemented with LIP funds allocated and expenditures incurred in DY's 7 and 8 (7/1/2012 – 6/30/2013 and 7/1/2013 –).

b) Timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding Methodology protocol. The State shall submit to CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period and all outstanding prior year LIP reconciliations. CMS will provide comments to the State on the reconciliation schedules within 30 days. The State will submit the final reconciliation schedule to CMS within 60 days of the original submission date.
c) Timely submission of all Demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.
d) Development and submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report". Within 60 days following the acceptance of the terms and conditions, the State must submit templates for these reports and anticipated timelines for report submissions.

CMS will assess penalties on an annual basis for the State's failure to meet tier-one milestones or components of tier-one milestones. Penalties of $6 million will be assessed annually for each tier-one milestone that is not met. Penalties will be determined by December 31st of each DY and assessed to the State in the following DY. LIP dollars that are lost as a result of tier-one penalties not being met, are surrendered by the State.

#71 13. **Tier-Two Milestones.** Tier-two milestones initiatives must drive from the three overarching goals of Three-Part Aim as described in paragraph 70(a). The initiatives will focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities must implement new, or significantly enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served (including low income populations) and meet established hospital specific targets, to receive 100 percent of allocated LIP funding. Tier-two milestones apply to facilities that receive the largest annual allocations of LIP funds and put at risk 3.5 percent of each of these facilities annual LIP allocation. The milestones apply to the 20 hospitals which are allocated the largest annual amounts in LIP funding. If the total annual LIP funds allocated for the 20 hospitals, do not total at least $700 million, the population of hospitals must be expanded until $700 million is reached.

Hospitals will be required to select and participate in 3 initiatives. Depending on the breath of health care activities undertaken by a facility, CMS may consider exceptions to the requirement that three initiatives must be implemented.

Once a facility is identified as a top 20 hospital, it must continue to achieve milestones to receive future DY LIP funding regardless of whether it drops out of the top 20 category. Exceptions to this requirement may be considered by CMS. Hospitals entering the top 20 category in future DYs will be subject to timelines similar to program planning/success and execution timelines.

Top 20 hospitals cannot select quality improvement initiatives under which it is currently receiving or may be eligible to receive other Federal dollars unless the LIP outcome goals are enhanced over previously established targets.

Within 90 days following the acceptance of the terms and conditions, CMS and the State will, through a collaborative process, finalize the plan and procedures including the specific health care initiatives, investments, and activities, and the applicable standards, measures, and evaluation protocols that will allow for the implementation and monitoring of tier-two milestones. CMS must approve the final plan and procedures which will require that tier-two facilities receiving funds in SFY 2011-2012 must submit its milestone plan by December 31, 2011, including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone.

Hospital initiatives that can be implemented under tier-two milestones, which are tied to the Triple Aim, include the following and are drawn from recent demonstration experiences:

a) Infrastructure Development – Investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services. Examples of such initiatives are:
   i. Increase in Primary Care capacity including residency programs and externships;
   ii. Introduction of Telemedicine;
   iii. Enhanced Interpretation Services and Culturally Competent Care; and,
   iv. Enhance Improvement Capacity;
b) Innovation and Redesign – Investments in new and innovative models of care delivery that have the potential to make significant, demonstrated improvements in patient experience, cost, and disease management. Examples of such initiatives are:
   i. Expansion of Medical Homes;
   ii. Primary Care Redesign; and,
   iii. Redesign for Efficiencies (e.g. Program Integrity).
c) Population-focused Improvement – Investments in enhancing care delivery for the 5 – 10 highest burden (morbidity, cost, prevalence, etc) conditions/services present for the population in question. Examples of such initiatives are:
   i. Improved Diabetes Care Management and Outcomes;
   ii. Improved Chronic Care Management and Outcomes;

iii. Reduction of Readmissions;
iv. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems);
v. Emergency Department Utilization and Diversion;
vi. Reductions in Elective Preterm Births; and,
vii. PICU and NICU Quality and Safety (e.g. pediatric catheter associated blood stream infection rates).

Between August 1, 2011 and December 31, 2011, the tier-two milestone facilities receiving funds in SFY 2011-2012 must submit a plan/program including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone. Subsequent year LIP funds allocated to these hospitals will be made available based upon the successful execution of the facilities targeted health care initiatives.

The State must assess a penalty of 3.5 percent of a facility's annual LIP allocation for failing to meet tier-two milestones or components of tier-two milestones. Penalties, if applicable, will be determined by December 31st of each DY and assessed to the facility in the remaining 6 months of the same DY. LIP dollars that are not paid out as a result of tier-two milestones not being met, are surrendered by the facility and State.