47. **Premiums and Co-Payments.** The State must pre-approve all cost sharing allowed by Reform plans. Cost-sharing must be consistent with the State Plan except that Reform plans may elect to assess cost sharing that is less than what is allowed under the State plan.

XII. DELIVERY SYSTEMS

48. **Health Plans.** The MCOs and capitated PSNs must be authorized by State Statute and must adhere to 42 CFR 438. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438. The certification shall identify historical utilization of State plan services used in the rate development process. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS Regional Office approval prior to implementation.

    a) Managed Care Organization MCO) – An entity that meets the requirements as described in 42 CFR 438.2.
    b) Provider Service Network (PSN) – An entity established or organized by a health care provider or group of affiliated health care providers that meet the requirements of Florida Statutes. A PSN may be reimbursed on a fee-for-service or capitated basis as specified in State statute.

49. **Freedom of Choice.** An enrollee's Freedom of choice of providers shall be limited to and through whom individuals may seek services, including the EBAP for populations enrolled in the Florida Medicaid Reform Demonstration. The State must provide Demonstration enrollees access to the MediPass or fee-for-service delivery systems as necessary to meet the choice requirements as under 42 CFR 438.52 and 42 CFR 42 438.56.

50. **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 Medicaid Reform 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.

XIII. LOW INCOME POOL

51. **Low Income Pool Definition.** The LIP provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim as described in paragraph 61(a). The LIP consists of a capped annual allotment of $1 billion total computable for each year of the Demonstration extension.

52. **Availability of Low Income Pool Funds.** Funds in the LIP are available to the State on an annual basis subject to any penalties that are assessed by CMS for the failure to meet milestones as discussed in Section XV "Low Income Pool Milestones". Funds available through the LIP may be reduced to recoup payments made to providers that are determined by CMS to have been made in excess of allowable costs. Any necessary recoupments will be achieved through a reduction of FFP claimed against current LIP payments. Available funds not distributed in a DY may be rolled over to the next DY. All LIP funds must be expended by June 30, 2014. LIP dollars that are lost as a result of penalties or recoupment are surrendered by the State and not recoverable.

53. **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. The State must submit the LIP reconciliations for DY 4 to CMS by May 31, 2012 and the reconciliations for DY 5 by May 31, 2013. The DY 4 and DY 5 reconciliations (required by May 31st of the respective year) may include "as filed cost report data" but will be considered the final reconciliation.

    If the reconciliations for DY 1, 2, and 3 identify LIP payments in excess of allowable cost consistent with paragraph 54 and the Reimbursement and Funding Methodology document implementing the LIP, the State must modify the Reimbursement and Funding Methodology applicable to DY 6 to ensure that payments under the LIP are consistent with the LIP goals and that providers will not receive payments that exceed their costs utilizing the cost reconciliation information to inform payment methodology modifications. CMS will also work with the State to identify modifications to the Methodology to address any cost documentation or audit processes necessary to fully meet cost reconciliation requirements. Any changes required by CMS will be applied prospectively to payments and audits for DY 6. The State may claim LIP payments based on the existing Methodology during the 60 day reconciliation finalization period. Claims after that period can only be made on the modified final Reimbursement and Funding Methodology approved by March 1, 2012. Changes to the Reimbursement and Funding Methodology document requested by the State must be approved by CMS and are only approved for DY 6 LIP expenditures.

    DY 4 reconciliation results will be reflected in the Reimbursement and Funding Methodology document for DY 7. If the final reconciliations for DY 4 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in DY 7 will not result in payments in excess of allowable cost, particularly methodologies that provide payments to providers that have received payments during any prior demonstration year in excess of allowable costs as defined in paragraph 54 and the Reimbursement and

Funding Methodology. Any required modifications to the DY 7 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for DY 7 LIP payments.

DY 5 reconciliation results will be reflected in the Reimbursement and Funding Methodology document for DY 8. If the final reconciliations for DY 5 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in DY 8 will not result in payments in excess of allowable cost, particularly methodologies that provide payments to providers that have received payments during any prior demonstration year in excess of allowable costs as defined in paragraph 54 and the Reimbursement and Funding Methodology. Any required modifications to the DY 8 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for DY 8 LIP payments.

The State shall by February 1, 2012 and each successive February 1st of the renewal period, submit a protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP as described in paragraph 51 and that providers receiving LIP payments do not receive payments in excess of their cost of providing services. FFP is not available for LIP payments until the protocol is finalized and approved by CMS.

54. **Low Income Pool Permissible Expenditures.** Funds from the LIP may be used for health care costs (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care costs may be incurred by the State, by hospitals, clinics, or by other provider types to furnish medical care for the uninsured and underinsured for which compensation is not available from other payors, including other Federal or State programs. Such costs may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS. These health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments).

55. **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.

56. **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 53.

57. **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.

58. **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.

59. **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.

XIV. LOW INCOME POOL MILESTONES

60. **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 61 and 62, 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.

61. **Tier - One Milestone.** Tier-one milestones are defined as follows:

    a) Development and implementation of a State initiative that requires Florida to allocate $50 million in total LIP funding in DY 7 and DY 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim.
        i. Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;
        ii. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,
        iii. Reducing per-capita costs.

        Expenditures incurred under this program must be permissible LIP expenditures as defined under Section XIII, Low Income Pool. The State will utilize DY 6 to develop the program. The program must be implemented with LIP funds allocated and expenditures incurred in DYs 7 and 8.
    b) Timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding

Methodology protocol. The State shall submit to CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period. CMS will provide comments to the State on the reconciliation schedules within 30 days. The State will submit the final reconciliation schedule to CMS within 60 days of the original submission date.

c) Timely submission of all Demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.
d) Development and submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report". Within 60 days following the acceptance of the terms and conditions, the State must submit templates for these reports and anticipated timelines for report submissions.

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.

62. **Tier-Two Milestones.** Tier-two milestones initiatives must drive from the three overarching goals of the Three-Part Aim as described in paragraph 61(a). The initiatives will focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities must implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served (including low income populations) and meet established hospital specific targets, to receive 100 percent of allocated LIP funding. Tier-two milestones apply to facilities that receive the largest annual allocations of LIP funds and put at risk 3.5 percent of each of these facility's annual LIP allocation. The milestones apply to the 15 hospitals which are allocated the largest annual amounts in LIP funding. If the total annual LIP funds allocated for the 15 hospitals, do not total at least $700 million, the population of hospitals must be expanded until $700 million is reached.

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

Once a facility is identified as a top 15 hospital, it must continue to achieve milestones to receive future DY LIP funding regardless of whether it drops out of the top 15 category. Exceptions to this requirement may be considered by CMS. Hospitals entering the top 15 category in future DYs will be subject to timelines similar to program planning/success and execution timelines.

A top 15 hospital cannot select quality improvement initiatives under which it is

currently receiving or may be eligible to receive other Federal dollars unless the LIP outcome goals are enhanced over previously established targets.

Within 90 days following the acceptance of the terms and conditions, CMS and the State will, through a collaborative process, finalize the plan and procedures including the specific health care initiatives, investments, and activities, and the applicable standards, measures, and evaluation measures and protocols that will allow for the implementation and monitoring of tier-two milestones and evaluation of the impact of these initiatives. The specific metrics chosen should support the measurements required in paragraph 80 (a)(vii-ix). CMS must approve the final plan and procedures which will require that tier-two facilities receiving funds in SFY 2011-2012 must submit its milestone plan by March 31, 2012, including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone.

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

a) Infrastructure Development – Investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services. Examples of such initiatives are:
   i. Increase in Primary Care capacity including residency programs and externships;
   ii. Introduction of Telemedicine;
   iii. Enhanced Interpretation Services and Culturally Competent Care; and,
   iv. Enhanced Performance Improvement Capacity;
b) Innovation and Redesign – Investments in new and innovative models of care delivery that have the potential to make significant, demonstrated improvements in patient experience, cost, and disease management. Examples of such initiatives are:
   i. Expansion of Medical Homes;
   ii. Primary Care Redesign; and,
   iii. Redesign for Efficiencies (e.g. Program Integrity).
c) Population-focused Improvement – Investments in enhancing care delivery for the 5 – 10 highest burden (morbidity, cost, prevalence, etc) conditions/services present for the population in question. Examples of such initiatives are:
   i. Improved Diabetes Care Management and Outcomes;
   ii. Improved Chronic Care Management and Outcomes;
   iii. Reduction of Readmissions;
   iv. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems);
   v. Emergency Department Utilization and Diversion;
   vi. Reductions in Elective Preterm Births; and,
   vii. PICU and NICU Quality and Safety (e.g. pediatric catheter associated blood stream infection rates).

Between January 1 2012 and March 31, 2012, the tier-two milestone facility's receiving funds in SFY 2011-2012 must submit a plan/program including baseline data and

outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone. Subsequent year LIP funds allocated to these hospitals will be made available based upon the successful execution of the facilities targeted health care initiatives.

The State must assess a penalty of 3.5 percent of a facility's annual LIP allocation for failing to meet tier-two milestones or components of tier-two milestones. Penalties, if applicable, will be determined by December 31st of each DY (with the exception of DY 6, which will be determined by March 31, 2012) and assessed to the facility in the remaining 6 months of the same DY. LIP dollars that are not paid out as a result of tier-two milestones not being met, are surrendered by the facility and State.

XV. GENERAL FINANCIAL REQUIREMENTS

63. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XVI.

64. **Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit.** All expenditures for health care services for Demonstration participants and categories, as described in section (d), are subject to the budget neutrality agreement. The following describes the reporting of expenditures subject to the budget agreement:

    a) Tracking Expenditures. In order to track expenditures, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number (11-W-00206/4) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered or for which capitation payments were paid.

    b) Cost Settlements. For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 and 10C. For any cost settlement not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

    c) Pharmacy Rebates. The State may propose a methodology for assigning a portion

implemented through State Medicaid Director letters, other memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

79. **PMPM Expenditure Review.** CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, no later than 6 months after the end of each Demonstration year, the State will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in paragraph 19. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide for the PCCM budget limit, if the State exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 6	Years 1 through 6 combined budget neutrality cap plus	1 percent
Year 7	Years 1 through 7 combined budget neutrality cap plus	0.5 percent
Year 8	Years 1 through 8 combined budget neutrality cap plus	0 percent

XVII. EVALUATION OF THE DEMONSTRATION

80. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval, within 120 days from the award of the Demonstration, a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on target populations for the Demonstration.

    a) Domains of Focus – The State must propose as least one research question that it will investigate within each of the domains listed below. The research questions should focus on processes and outcomes that relate to the CMS Three-Part Aim of better care, better health, and reducing costs. With respect to domains vii, viii, and ix, the State must propose two research questions under each domain (one each from Tier-One and Tier-Two milestones).

        i. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
        ii. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
        iii. Participation in the Enhanced Benefits Account Program and its effect on participant behavior or health status;
        iv. The impact of the Demonstration as a deterrent against Medicaid fraud and abuse;

v. The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
vi. The effect of LIP funding on disparities in the provision of healthcare services, both geographically and by population groups;
vii. The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
viii. The impact of Tier-One and Tier-Two milestone initiatives on population health; and,
ix. The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.

b) Evaluation Design – The draft design must discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

81. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS' comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the current Demonstration period. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.

82. **Cooperation with Federal Evaluators.** Should CMS conduct an evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XVIII. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
60 days following the end of the quarter	Quarterly Progress Reports	Section IV, STC 19
120 days following	Annual Report	Section IV, STC 20