Florida Medicaid Reform

Application for 1115 Research and Demonstration Waiver

August 30, 2005

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I. Statement of Purpose

The Florida Medicaid program was created in 1970. Like many states, Florida operates its Medicaid program in a centralized fashion, with the government taking the lead in structuring coverage and making direct payments to providers. Medicaid-eligible individuals are often left out of the decision-making process and must seek services on their own with little understanding of service options and alternatives. Florida seeks to create a new Medicaid program that recognizes the individual's role in planning and purchasing health care services, provides transparency in the performance of health care plans and providers, assures access to quality service, provides stability to Florida budgeting, reduces confusion about coverage, and leverages the dollars spent to measurably improve service and invest in prevention. The new Medicaid system will rely heavily on measurement of, and transparency in, outcomes.

Medicaid covers 2.2 million Floridians. Both enrollment and expenditures are growing, and it is clear the current design is unsustainable for reasons that include:

- Program expenditure growth has averaged 13% per year over the past six years. In 2005, Medicaid will represent approximately 24% of the entire state budget with total expenditures exceeding $14 billion dollars. If these trends continue, it is anticipated that by 2015 Medicaid will represent 59% of the state's total budget with expenditures over $50 billion dollars.

- Florida covers over 47 different services on a fee-for-service basis and through contracted managed care entities. Individuals can receive care through 11 contracted HMOs; the statewide primary care case management (PCCM) system, MediPass; or three enhanced PCCM systems. In addition, the state maintains several carve-out programs for mental health services and dental care. These multiple delivery systems, representing more than 80,000 providers and generating more than 140 million individual claims, have become increasingly difficult to sustain. Additionally, this episodic system, where dollars are only paid once people have an interaction with a health care provider – typically once they are ill – does not leverage the dollars spent to improve the health status of the Medicaid population. A more properly designed system would create incentives for identifying recipients with chronic health conditions rather than waiting until the conditions become so severe they need intensive and expensive treatment.

- Florida operates 20 distinct waivers that provide authority for various programs. Specifically, Florida has 13 home and community-based waivers, two 1115 Research and Demonstration Waivers and five 1915(b) waivers for managed care or selective contracting. Florida's waiver programs are needed to provide the state enough flexibility to serve its neediest residents, control costs and monitor quality. However, each new waiver program complicates overall management of Medicaid.

The result is a large, complex and cumbersome system that is difficult for people to navigate and the state to manage. While costs continue to escalate, the number of people dissatisfied with the program also grows, and individuals feel like second class citizens due to the stigma of public assistance.

Another factor contributing to the need to reform Medicaid is fraud and abuse. While as much as one-third of all Florida Medicaid recipients are served through a managed care delivery system, the remaining two-thirds of the population are served through the traditional fee-for-service program. Currently approximately 80,000 providers are enrolled as fee-for-service providers. As in most state Medicaid programs, the incidence of fraud and abuse is found predominately in fee-for-service. Florida Medicaid is recognized as a leader in the battle against fraud and abuse and has put in place many automated and manual safeguards to detect and prevent inappropriate payments. We have had some success; however, with a $14 billion program and so many providers operating in a fee-for-service environment that generates more than 140 million individual claims, it is doubtful that additional substantial gains can be realized without reforming the basic principles that guide the program. Converting to a premium-based system will reduce fraud and abuse inherent in a large and complex fee-for-service system.

Due to increasing dissatisfaction and the mounting strain on state resources, Medicaid must change. The current system is often incapable of meeting participants' needs, and it is costly and inefficient. The change cannot be timid or tentative. It must fundamentally transform relationships, responsibilities and economic incentives. The Florida Medicaid Reform model provides the framework for this change - without eliminating services or eligibility.

II. Florida Medicaid Reform

Under Medicaid Reform, the state's role will change so that it is largely a purchaser of care, and oversight will focus on improving access and increasing quality of care. Individuals will have the ability to select plans that meet their needs. The state will continue to foster and protect its safety net providers.

The state will transform Medicaid by integrating key principles of reform in the structure and daily operation of the Medicaid program. The Florida Medicaid Reform Model comprises comprehensive and catastrophic coverage, an individual enhanced benefit account, or a subsidy to individuals with access to employer-sponsored insurance (ESI). An overview of the principles and structure of Florida Medicaid Reform is provided below.

Principles governing Medicaid reform are:

Patient Responsibility and Empowerment – The fundamental basis of the reform rests upon two critical inputs: transparency and consumer empowerment. The state will invest in an infrastructure to ensure a measurement of performance of all plans and providers combined with public reporting of consumer satisfaction with their plans and providers. With this information in hand, and with the support of choice counselors, individuals will then be expected to take an active role in their health care. They will purchase or select a managed care plan directly. They will have the flexibility to choose from a variety of benefit packages and be able to choose the package that best meets their needs. Additionally, they will be rewarded for demonstrating healthy practices and personal responsibility. Florida expects family and individual satisfaction to increase through enhanced personal control and choice. Moreover, Florida anticipates that individual health outcomes will improve as people take an active role in managing and understanding their health care needs. With a focus on transparency and public reporting of outcomes, the plans participating in the Medicaid program will have a significant incentive to work toward improvement of the health status of enrollees who have chosen their plans.

Marketplace Decisions – The state will reshape its role in health care from that of a centralized decision maker that creates and manages health care services to a purchaser of health care services responsible for ensuring the systems of care delivery meet the higher standards and follow the rules for ensuring delivery of quality services. In this new environment, market competition will inspire innovation and efficiency in Medicaid coverage. Managed care plans will have the ability to create customized packages to meet the needs of specific Medicaid groups. Florida expects that the benefits offered will be at least comparable to health care coverage in the private market and provide for increased access to care. For the first time, Medicaid enrollees will be able to measure the performance of the care delivery system and, through the exercise of choice,

have a direct impact on the system – which today is not possible in the fee-for-service environment.

Bridging Public and Private Coverage – Individuals with access to employer-sponsored insurance (ESI) coverage will be offered the choice to "opt out" of Medicaid. Individuals will be able to decide this at the time of eligibility determination or at any time they are offered access to an ESI plan. This choice will help bridge the gap to independence by providing individuals with a subsidy to move to private health insurance coverage.

Sustainable Growth Rate – Medicaid will move to a premium-based system. In this model, the state will set aside a specific amount of money for each person enrolled in Medicaid. Each managed care entity's premium will be risk adjusted for health status to better reflect utilization of medical services by its enrollees. Additionally, Florida will establish a maximum benefit limit similar to what already exists in private insurance.

These principles will empower participants, provide flexibility to providers, and facilitate program management for government. This philosophy builds upon the themes expressed in the President's New Freedom Initiative by providing individuals greater opportunity to take charge of their health care needs.

Under Florida Medicaid Reform, there are four fundamental elements:

Risk-Adjusted Premiums will be developed for Medicaid enrollees in managed care plans. The premium will have two components, comprehensive care and catastrophic care, and will be actuarially comparable to all services covered under the current Florida Medicaid program. All Medicaid Reform enrollees will have access to the full premium when choosing a managed care plan. The risk-adjusted premium will minimize the phenomenon of "adverse selection," and in fact, provides an incentive for plans to take all necessary steps to identify Medicaid enrollees who have undiagnosed chronic conditions. Once a Medicaid enrollee has chosen a plan, the plan may receive a higher premium only if the enrollee has been diagnosed with a condition that merits the additional premium. Of course, once a plan has identified someone with a chronic condition, it is then to the plan's financial benefit to properly manage the enrollee's condition so as to avoid higher cost services typical of untreated chronic conditions.

Enhanced Benefits Accounts will be established to provide incentives to Medicaid Reform enrollees for healthy behaviors. For instance, if people with diabetes, asthma or heart disease participate in a disease management program, they could earn the incentive. Or, if a smoker's plan offers a smoking cessation program, they could earn the incentive by participating in the program. As enrollees earn access to these incentives, funds will be deposited into individual Enhanced Benefits Accounts, and enrollees may use these funds to offset health-care-related costs, such as over-the-counter pharmaceuticals, vitamins etc. Enrollees who participate in Medicaid Reform, but who later lose Medicaid eligibility will retain access to funds in their Enhanced

Benefits Accounts. These individuals will be eligible for Medicaid only through the waiver and only for purposes of drawing down enhanced benefits funds earned prior to loss of Medicaid eligibility. They will not be eligible for any other Medicaid benefits. These individuals will be considered an expansion population under the waiver.

Employer-Sponsored Insurance (ESI) option will provide individuals with the opportunity to use their premiums to "opt out" of Medicaid to purchase insurance through the workplace. Individuals eligible for Medicaid will be able to direct their premiums for use as a subsidy for the employee share of ESI, or as premium payment into a private plan if the individual is self-employed. If the ESI share or self-employed insured premium is greater than the Medicaid premium, the enrollee will be responsible to pay the additional amount.

Low-Income Pool (LIP) will be established and maintained by the state to provide direct payment and distributions to safety net providers in the state for the purpose of providing coverage to the uninsured. Funds will be distributed to safety net providers that meet certain state and federal requirements.

Florida Medicaid Reform will introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost. The state believes more integrated models that expand the medical home concept to manage all care provides additional opportunity to better manage care. Therefore, the state will increase the number of individuals enrolled in comprehensive plans that are capable of managing all of an individual's care. In addition, the state will allow flexibility to plans to structure benefit packages to better serve individuals – while ensuring that benefits offered are actuarially comparable to the needs of the population.

The state is seeking to increase the number of individuals in a capitated or premium-based managed care program and reduce the number of individuals in a fee-for-service program. Specifically, under Medicaid Reform many of the individuals currently in a fee-for-service program would move to a plan that is responsible for coordinating, managing and being held accountable for all of their care. Appendix I provides an overview of Florida managed care programs. The state anticipates that comprehensive plans, compared to limited-benefit carve-out programs, will improve health outcomes and reduce inappropriate utilization. The state will demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve.

Moving from fee-for-service to a premium-based environment will serve as an effective deterrent against fraud and abuse. The state will maintain strict oversight of managed care plans and will adapt its fraud efforts to surveillance of fraud and abuse within the managed care system – a prospect that will lead to more efficient efforts than the current system of monitoring approximately 80,000 providers and more than 140 million claims. Providers will be held accountable by managed care plans, as well as by Medicaid recipients, who will be more involved with providers during the treatment of their health care needs.

In addition, the state will provide these managed care plans with additional flexibility in creating benefit packages to meet the needs of specific groups. The state anticipates that the added flexibility in developing a benefit package will increase plan participation and provide additional choice to individuals. While plans currently have the ability to provide additional services as well as substitute services, expansion of services is limited because of the requirement to provide a "standard set" of services. Through this reform initiative, flexibility in structuring the comprehensive benefit package will provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

The state will implement Medicaid Reform in phases, and, upon full implementation, the Medicaid Reform Model will be the primary delivery system statewide. The state will include other waiver programs in the Medicaid Reform Model as it expands.

The 2005 Florida Legislature passed Senate Bill (SB) 838 authorizing the Agency to seek an experimental, pilot, or demonstration project waiver, pursuant to section 1115 of the Social Security Act (SSA) to create a statewide initiative to provide a more efficient and effective service delivery system that enhances quality of care and outcomes in the Florida Medicaid Program.

To effectively implement the program, Florida is requesting a section 1115 Research and Demonstration waiver in order to waive statutory provisions under section 1902 of the Social Security Act and obtain expenditure authority that permits the state to provide maximum flexibility in administering Florida's Medicaid program. Specifically, the state requests waivers of statutory provisions to provide for:

- Approval and federal financial participation (FFP) for Medicaid Reform benefits with cost-sharing for all Medicaid eligibility categories participating in the waiver.

- Approval and FFP for the ESI option with cost-sharing, if applicable.

- Approval and FFP for enhanced benefits expenditure.

- Approval and FFP for the expansion population (e.g. persons who have lost Medicaid eligibility) to provide access to accrued balances in the Enhanced Benefits Account for individuals below 200% of the federal poverty level (FPL) who would otherwise not be eligible for Medicaid.

- Approval and FFP for funds disbursed through the Low-Income Pool to eligible providers.

III. Eligibility and Enrollment

A. Eligibility for Medicaid

The Department of Children and Families (DCF) is the administering agency responsible for processing Medicaid applications and determining Medicaid eligibility. The state will continue to use the same application and eligibility processes for all individuals, including participants in Medicaid Reform. Current income and asset limits will apply under Medicaid Reform, as will current residency and citizenship standards. There will be no limit on the number of individuals eligible for Medicaid as specified in the State Plan. The state assures that all applications will be processed in a timely manner. Eligibility will be limited to emergency services until an individual selects or is assigned to a managed care plan. If the individual does not select a plan in a timely manner, eligibility for full benefits will be delayed and not meet the timeline specified in 42 CFR 435.911.

B. Eligibility for Medicaid Reform

During the initial phase, participation in Medicaid Reform will be mandatory for two eligibility groups currently covered by Florida Medicaid. The first group is the 1931 eligibles and related group, herein referred to as the TANF and TANF-related eligibility group. The second is the Aged and Disabled group.

1. Mandatory Population

   a. TANF and TANF-Related Group - 1931 Eligibles:

   - Families whose income is below the TANF limit (23% of the FPL or $303 per month for a family of 3) with assets less than $2,000.
   - Poverty-related children whose family income exceeds the TANF limit as follows:
     - up to age one, family income up to 200% FPL
     - up to age 6, family income up to 133% of FPL
     - up to age 21, family income up to 100% FPL

   b. Aged and Disabled Group:

   - The aged and disabled, comprising persons receiving SSI cash assistance whose eligibility is determined by SSA (income limit approximately 75% of the FPL; asset limit for an individual is $2,000).
   - Children eligible under SSI.

The above groups are referred to as mandatory populations, with the exception of poverty level children up to age one with family income above 185 percent of FPL but below 200 percent of FPL.

2. Voluntary Populations:

The following individuals eligible under the above groups will be excluded from mandatory participation during the initial phase:

- individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD;
- children with chronic conditions who participate in Children's Medical Services;
- foster care children;
- individuals diagnosed with developmental disabilities;
- individuals eligible under a hospice-related eligibility group;
- pregnant women with incomes above the 1931 poverty level; and
- individuals with Medicare coverage.

During the initial phase, these individuals may voluntarily participate in Medicaid Reform. The state anticipates that during subsequent phases, individuals identified as voluntary in the above groups, as well as additional eligibility groups not included during the initial phase-in, will be mandated to participate in Medicaid Reform. Specifically, children with chronic conditions participating in Children's Medical Services, foster care children and individuals with developmental disabilities will be required to participate in a reform program upon development and implementation of networks to meet their needs, as specified in Section VI, Delivery Networks.

Individuals eligible for both Medicare and Medicaid will be required to participate in Medicaid Reform upon the development and inclusion of an integrated service delivery system for individuals aged 60 and older.

3. Expansion Population:

Individuals with incomes of less than 200 percent FPL, regardless of assets, who lose eligibility for Medicaid, will continue to have limited eligibility under Medicaid Reform. This expansion population retains Medicaid eligibility solely to access accrued funds in their individual Enhanced Benefit Account. The expansion eligibles will receive no other Medicaid benefits. The expansion population will be limited to individuals who have accrued funds in an individual enhanced benefit account.

C. Enrollment and Disenrollment

Within each demonstration area the state will stagger the transition for enrollment of mandatory populations into Medicaid Reform.

1. New Medicaid Enrollees:

At the time of eligibility determination, individuals in mandatory populations will receive information about the managed care plan choices in their area. They will be informed of their estimated premium based on information provided to DCF, and they will be informed of their option to select an authorized managed care plan or opt out of Medicaid. Individuals will be given the opportunity to meet with a choice counselor (either state-employed or state-designated) to obtain additional information in making a choice. If they opt out, they can use their premium to pay for employer-sponsored insurance, or private health insurance if they are self-employed. They will be required to select a plan or opt out within 30 days of eligibility. If the individual does not select a plan or opt out within the 30-day period, the state will auto-assign the individual. Once individuals have made their choice, they will be able to contact the state or the state's designated choice counselor to register their plan selection. The eligibility process will be considered complete once the individual has selected a managed care plan or has chosen to opt out of Medicaid. Until the individual makes a choice, or the individual is auto-assigned, the individual is not considered enrolled in Medicaid and is eligible for emergency services only.

2. Current Medicaid Enrollees:

For current Medicaid enrollees in a mandatory population residing in a demonstration area, a staggered transition to enrollment in Medicaid Reform will occur. Current Medicaid enrollees who are enrolled in a managed care plan or the MediPass program will be required to enroll in a reform plan at the time of their eligibility redetermination, or their open enrollment period, whichever is sooner. During the transition period, current enrollees will be able to remain with their current managed care plan if it continues to provide the currently contracted package, either under the current contract or as a reform plan with the same benefit package. The state may create an open enrollment process for all enrollees in a plan if the plan no longer has a contract with the state or develops a plan that is different from the current managed care plan without maintaining the current benefit package. In this instance, since the plan is different, the state will allow all enrollees in the plan to remain enrolled in the plan or select a new reform plan.

Once an individual is redetermined eligible for Medicaid, enrollees will have 30 days to make a choice of a reform plan. If the individual does not make a selection, the state will auto-assign the individual to a reform plan to ensure that services will continue uninterrupted.

Medicaid recipients in the demonstration areas who are not currently enrolled in a capitated managed care plan upon implementation of Reform will have the opportunity to enroll in a managed care plan at the time of annual eligibility redetermination. An information and redetermination packet will be sent to the enrollee at least 45 days prior to the redetermination date. This packet will include information on the managed care plan choices in the area information on the opt-out option. The individual may choose to meet with a choice counselor to discuss the options. If the individual does not make a selection, the state will auto-assign the individual to a managed care plan to ensure that services will continue uninterrupted.

All current enrollees may voluntarily elect to enroll in a reform plan prior to their redetermination period. The state will treat the request to disenroll from the current plan as a good cause disenrollment request and allow the individual to enroll in the reform plan. In addition, all current Medicaid enrollees, regardless of the delivery system in which they are enrolled prior to Reform, may opt out of Medicaid at any time after the demonstration implementation date in their area. Please see Section V for more information.

3. Auto-Assignment

Each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the state or state's designated choice counselor will provide information to the individuals to encourage an active selection. Enrollees that fail to choose within this timeframe will be auto-assigned to a managed care plan. At a minimum, the state will 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 are:

- A managed care plan has sufficient provider network capacity to meet the need of enrollees.
- The managed care plan has previously enrolled the enrollee as a member, or one of the plan's primary care providers has previously provided health care to the enrollee.
- The state has knowledge that the enrollee has previously expressed a preference for a particular managed care plan as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.
- The managed care plan's primary care providers are geographically accessible to the recipient's residence.

For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a managed care plan, the state will determine whether the SSI recipient has an ongoing relationship with a provider

or managed care plan. If so, the state will assign the SSI recipient to that managed care plan whenever feasible. This will allow the state to facilitate continuity of care for SSI recipients who have an ongoing relationship with a provider. Those SSI recipients who do not have such a provider relationship will be assigned to a managed care plan using the assignment criteria previously outlined.

4. Lock-In/Disenrollment

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

The choice counselor will record the plan change/disenrollment reason for all recipients who request such a change. The state or the choice counselor will be responsible for processing all enrollments and disenrollments.

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

5. Opt-Out: Employer-Sponsored Insurance

Enrollees will be able to opt out of Medicaid at any time to enroll in an employer-sponsored insurance program. The decision to opt out of Medicaid and elect employer-sponsored insurance is completely voluntary. The state will provide an enrollee who chooses to opt out of Medicaid and enroll in an ESI plan with a 90-day change period. However, an enrollee who chooses to opt out of Medicaid and enrolls in an ESI plan may not have the entire 90-days to switch plans or opt back into a Medicaid managed care plan. The change period may be limited by the employer's open enrollment period. During the change period the enrollee may opt back in to Medicaid and select a managed care plan. After the change period, no further changes may be made until the individual's open enrollment period, the next employer-sponsored open enrollment period, certain qualifying events, or unless the enrollee no longer has access to employer-sponsored insurance.

6. Re-enrollment:

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

D. Information and Choice: The Choice Counselor

1. Enrollee Choice

Enrollees in the demonstration sites will initially have the choice of enrolling in a reform plan or to opt out of Medicaid. At a minimum, an individual in a demonstration area will have a choice of the following:

- One reform plan and MediPass;
- Two or more reform plans

The state assures CMS that it will comply with section 1932(a)(3) and 42 CFR 438.52, relating to choice since at least two options will be available in all demonstration areas. Recognizing the unique attributes of Florida's rural communities, the state will foster the development of networks and plans in rural areas in an effort to provide individuals with two or more options.

2. Enrollee Information

The state intends to contract with an independent choice counselor to ensure that enrollees are provided with full and complete information about managed care plan choices and the ability to opt out of Medicaid. As directed by the

Legislature, the state will develop a choice counseling system that promotes health literacy and provides information aimed to reduce minority health disparities thorough outreach activities. As defined in Healthy People 2010, health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions, including the selection of a managed care plan. The choice counselor will provide information regarding an individual's choice to select a reform plan or opt-out of Medicaid while promoting health literacy to ensure that information is effectively communicated and understood.

Through the choice counselor the state will develop an extensive enrollee education and rating system so individuals will fully understand their choices and be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly. Specifically, the choice counselor will provide information on either selecting a reform plan or opting out of Medicaid.

The choice counselor will provide information to individuals interested in opting out, explain the concept and reenrollment provisions and provide contact information regarding the administrator. The choice counselor will assist the individual in making an informed choice about opt-out by highlighting information the individual will need to consider in order to make a fully informed choice. Individuals interested in opt-out will be encouraged to contact their employer and the state's contract administrator for the opt-out program for additional information. The choice counselor will collect information on whether the individual has access to health insurance. At a minimum, the choice counselor will encourage the individual to determine available health insurance; when the individual can enroll; review of cost-sharing requirements of the plan; information about preexisting conditions clauses; and whether individual or family coverage is available. The choice counselor will then refer the individual to the state's administrator, which will assist the individual in the opt-out process. Specifically, the administrator will contact the employer and verify available health insurance. To ensure enrollees understand this option, the administrator may periodically contact individuals regarding the opt-out option. This outreach process will enhance awareness of the program and help ensure coordination with the employer's time frame for open enrollment and qualifying events.

As it does now, the state or the state's designated choice counselor will provide information about each plan's coverage in accordance with federal requirements. Additional information will include, 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. Individuals will be assured of equal value among plans since all plans will be actuarially equivalent. In addition, the state will supplement coverage information by providing performance information on each plan. Information provided 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. Such a system will better convey the performance of the managed care plans in an easy-to-understand format. Finally, as an additional safeguard, the state will develop a system to ensure that there is a record of an individual's acknowledgement that choice counseling has been provided.
One of the goals of choice counseling will be to improve health literacy by increasing an individual's exposure to and ability to search for, obtain, and use health information. The goal of the health literacy component is to educate individuals about gaining access to the managed care plan. The state believes that by increasing health literacy levels this will assist individuals in making informed choices in selecting a plan that meets their needs which will result in an increase in demand for appropriate services and decrease demand for inappropriate services. The overall result will improve the health status of all Medicaid enrollees. The state will also encourage each plan to use alternative mechanisms for dissemination of materials to promote health literacy, such as Internet, case management or similar programs.

Choice counseling materials will be provided in a variety of ways including print, telephone, and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when five 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. Individuals will be able to contact the state or the state's designated choice counselor to obtain additional information. 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 assures CMS that it will provide information in accordance with Section 1932(a)(5) of the Act and 42 CFR 438.10, Information Requirements.

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

E. Marketing

Approved managed care plans will be allowed to market to individuals within the parameters defined by law to prevent inappropriate or unfair marketing. With prior approval from the state, direct marketing will be permitted and may include direct mailings, health fairs, and other activities. The state will assure that all plans comply with section 1932(d)(2) of the Act and 42 CFR 438.104, Marketing Activities.

All materials provided by the plans will meet the requirements at 42 CFR 438.10, Informing Requirements, including being written at a fourth-grade reading level. The state will require translation of all enrollment and marketing materials in areas where a specific language is spoken by five percent or more of the population. In addition, the choice counselor and plans will provide oral translation services to all individuals, regardless of the language spoken. Plans will be required to have TTY/TDD service available for enrollees with hearing and speech impairments.

In addition, the state will maintain strict oversight of marketing activities. The state will continue to apply and enforce federal and state marketing restrictions that currently apply to plans. In addition to the federal requirements, Florida law prohibits plans from offering gifts or other incentives to potential enrollees and managed care plans from providing inducements to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans.

IV. Benefits

Medicaid Reform will provide individuals with health care options that will allow them to better manage their health care and will serve as a bridge to private coverage options. Currently, the Medicaid benefit package is one-size-fits all, leaving Medicaid enrollees with a single option for services, regardless of need. In many of the benefit "silos" that exist today, there are statewide limits and caps on various services that have varying impact on local populations. For example, a cap on outpatient hospital services, while having a minimal impact on a recipient in an urban or suburban area due to other outpatient-based alternatives, has a definitive impact on a recipient in a rural community where other outpatient options may be limited. Similarly, limits on home health visits, various diagnostic services or pharmaceutical limitations that are developed on a statewide basis may have varying degrees of impact on the population. Medicaid Reform will provide health plans with the flexibility to develop customized benefit packages that better fit and are more appropriate for Medicaid enrollees. Since these plans will be defined locally and will likely take advantage of varying strengths of the providers in that community, they will be more appropriate to the needs of that particular population. Such packages will more closely resemble private plans, yet will be actuarially equivalent to the current Medicaid benefit package. The state expects that additional flexibility in benefit design will result in competition-inspired innovation and efficiency that will increase individual access to care. Each plan will face the competitive pressure of offering the richest possible package within the limits of the premium offered by the state. As the delivery of medicine changes, so will the benefit packages. As an example, while inpatient hospitalization was the largest funding category within Medicaid 10 years ago, today prescription costs have outpaced inpatient hospitalization. Drawing upon this experience, as each plan better manages the higher-cost services and shifts to the outpatient options that advances in medicine allow, each plan will likely shift its benefit offerings. At all times, the state will ensure that services like inpatient hospitalization are available at an actuarially appropriate level based upon the utilization patterns of the recipients. The state seeks to ensure that needed services are covered and provided. With increased choices, individuals will be able to use their premium to select benefit plans that best meet their needs.

Each health care plan will submit its proposed benefit package to the state for prior approval. The state will evaluate the proposed benefit package using a two-pronged test: (1) actuarial equivalency and (2) sufficiency of benefits.

To encourage wide health plan participation in Medicaid Reform, the state will separate the Medicaid premium into two components – comprehensive care and catastrophic care. The state will develop premiums based on historical utilization for both components. Participating health plans will assume financial risk for the comprehensive care component. However the state will establish criteria to allow some health plans to choose whether or not they will assume risk for the catastrophic care component. (Refer to Section IV: Delivery System for criteria.) If the plan chooses not to assume the

risk for the catastrophic care component, the state will retain financial responsibility for costs that exceed the catastrophic threshold. An example of the potential need to allow a plan the option not to accept catastrophic risk would be in the rural communities where the "critical mass" of lives may not be sufficient for a plan to absorb all the risk. In instances like this, in an effort to encourage a plan to serve the rural community, the state may permit an otherwise fully licensed managed care plan to serve the community while the state retains the risk for the catastrophic component. In this case, the state would pay only the comprehensive care portion of the premium to the plan, and retain the catastrophic portion.

Finally, Medicaid Reform will create the Enhanced Benefit plan, which the state will fund through savings. The purpose of the Enhanced Benefit plan is to offer incentives to enrollees to participate in wellness activities. These activities will be designed to improve and/or maintain the enrollee's health. Medicaid Reform enrollees can earn healthy behavior credits that will be deposited into an Enhanced Benefit Account they can use for out-of-pocket medical expenses. Rewarding healthy behavior helps both the enrollees and the state – enrollees are healthier, and, when enrollees are healthier, the state saves money.

These three elements – *customized benefit packages, comprehensive and catastrophic care component, and the Enhanced Benefit Plan* – form the core of a consumer-driven and market-inspired reformed Medicaid benefit package.

A. Customized Benefit Packages

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

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

All benefit packages must be prior-approved by the state and must be at least actuarially equivalent to the services provided to the target population under the current

State Plan benefit package. In addition to being actuarially equivalent to the value of traditional Medicaid services, each managed care plan's customized benefit package must pass a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population (e.g., TANF, aged and disabled, etc.). See below for more detail.

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

1. Actuarial Equivalency

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

Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid State Plan services. This process will ensure that, given a specified Medicaid target population and its historical utilization, the expected claim cost levels of all reform plans are equal (using a common benchmark reimbursement structure) to the level of the historic fee-for-service plan. The state will use 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 evaluation model will consider the following components of the benefit package: services covered; cost sharing; additional benefits offered, if any; and any global limits. Additional services offered by the plan will be considered a component of the plan's customized benefits and not a component of the Enhanced Benefit plan.

2. Sufficiency

In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet state-established standards of benefit sufficiency. These standards will be based on the target population's historic use of Medicaid State Plan services. In this evaluation the state will identify specific services (e.g., inpatient hospital, outpatient physician care, behavioral health, and prescription drugs) and will evaluate each proposed benefit plan against the sufficiency standard to ensure that the proposed benefits are adequate to cover the needs of the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for target population that is expected to exceed the plan's proposed benefit level. For example, the

sufficiency standard for physician services may be established at 95 percent of historical utilization for SSI eligibles.

Thus, in order for a health plan to obtain state prior approval of its proposed customized benefit package, the proposed benefit package must be actuarially equivalent to the current Medicaid State Plan benefits for each target population and must cover key benefits at a level sufficient to meet the needs of the target population. The state believes that the flexibility to offer customized benefit packages, combined with the two-pronged Benefit Plan Evaluation Model, will ensure optimal benefit packages for Medicaid Reform enrollees. Please see Appendix IV for the Benefit Plan Evaluation Prototype, which provides a copy of the draft protocol.

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

B. Comprehensive and Catastrophic Components

In a traditional capitated environment, a health plan receives one premium for managing financial risk and coordinating all care for an enrollee. This includes managing the financial risk of serving both the vast majority of Medicaid cases as well as those relatively few individuals who experience very high medical expenditures. To foster greater health plan participation, Medicaid Reform will divide the Medicaid risk into two components: comprehensive and catastrophic.

The state will establish an aggregate premium based on historical utilization of currently covered mandatory and optional services. Based on this aggregate premium, the state will develop a premium for each component. The comprehensive care component includes the Medicaid services that the majority of Medicaid enrollees will need and is expected to represent approximately 90 percent of historical medical expenditures. The catastrophic care component is designed to meet the needs of the limited number of Medicaid enrollees who have unusually high costs in any particular year. All reform plans will assume the comprehensive risk for their enrollees. For each target population served, plans may choose whether to assume the catastrophic risk as well.

The state believes that by establishing criteria that make the assumption of financial risk for the catastrophic component optional for select managed care plans, Medicaid Reform will: 1) promote managed care competition in all areas of the state including rural and underserved areas, and 2) attract new types of health plans to the Medicaid market. This further maximizes an individual's choice of available managed care plans. Individuals will have access to services covered by both premiums, regardless of whether their health plan or the state assumes the risk for the catastrophic component. In all cases, the model of payment of the premium will be invisible to the recipient, and will be a contractual issue between the plan and the state. The enrollee's services will

be provided seamlessly, regardless of how the premium is paid to the plan. Information on each component is provided below.

In development of the comprehensive benefits plan, the state recognizes the need for safeguards to ensure appropriate and adequate care for enrollees moving from comprehensive to catastrophic care. Thus, the state will require the following:

- *Integrated Plan Design* – One of the design options the state considered was to establish two separate plan designs, one for comprehensive and one for catastrophic. Under this scenario the catastrophic care plan would be a pre-determined set of benefits, established separately from the benefit limits in each customized benefit package. However, this design option leaves open the possibility that an individual could have a "doughnut hole" situation where the comprehensive plan exhausts its benefits, but the catastrophic plan does not yet pick up coverage.

  The state did not want to create a scenario where there may be gaps in coverage. The decision was made to craft the catastrophic care plan in an integrated fashion with the comprehensive care plan. Thus, the customized benefit package proposed by the health plan defines the set of covered benefits for the individual.

- *Seamless Care* – The Medicaid Reform enrollee will have access to the value of the entire premium, both comprehensive and catastrophic. Enrollees need not be concerned with whether their plan has accepted risk for the catastrophic care plan or whether the state is at risk for this premium. As indicated above, health plans will be required to coordinate and manage all care, comprehensive and catastrophic, regardless of whether the entity has assumed financial risk for the catastrophic component. This ensures a seamless delivery system for the enrollee.

It is important to note that the comprehensive/catastrophic distinction is with respect to development of the premium and related only to the risk level the plan will retain. From the enrollee's perspective there is only one benefit package, specifically the package chosen, and coverage is seamless. Under this model, the combination of the comprehensive and catastrophic components is subject to the overall limits of the customized benefit package. The sole exception to that statement is hospital inpatient stays, which are discussed in more detail later.

1. Comprehensive Component

The comprehensive care component of the Medicaid premium will provide health care coverage to Medicaid Reform enrollees. It is expected to represent approximately 90 percent of expected medical expenditures for the reform recipients. This component will cover 100 percent of the cost of an enrollee's care, less any required enrollee cost sharing, until that care reaches a pre-

established threshold. At that time the expenses for care, less any required plan co-insurance, become subject to the catastrophic component. Through a plan cost sharing mechanism, a small portion of the expenses over the threshold will be retained within the comprehensive component of the premium to ensure that plans not bearing catastrophic risk have financial motivation to continue to manage care efficiently. The actual proportion of the total premium dedicated to the comprehensive component will depend upon the threshold level and the post-threshold plan co-insurance established for the catastrophic component. The proportion may vary among target populations.

Initially, comprehensive care premiums may be based on eligibility groups, age, and gender for a specified geographic area and then risk adjusted for health status. Health plans will be at risk for the comprehensive care premium and will provide all services outlined in their customized benefit packages approved by the state. The comprehensive care component will include most services for most Medicaid enrollees and must be sufficient to meet the needs of the target population.

2. Catastrophic Component

The catastrophic premium component covers the bulk of an individual's medical expenses, less any required plan cost sharing, after those expenses exceed a pre-established catastrophic threshold. The state will establish criteria that offers some health plans a financial choice for managing high cost cases – accept the premium and self-insure, or reject the premium and have the state act as re-insurer. The option to accept the catastrophic component will be limited to areas where there are no HMOs as of the implementation date. For counties in which there is an HMO operating, licensed managed care plans will be required to assume financial responsibility for both comprehensive and catastrophic coverage. PSNs will have the option to assume financial responsibility for catastrophic coverage only when they meet financial standards consistent with requirements in Chapter 641. Health plans with experience serving the Medicaid market and operating in a risk-based environment will likely choose to accept the catastrophic premium and the associated risk. Newly established health plans or those new to a risk-based environment will likely choose to forgo the catastrophic premium and let the state act as a re-insurer for high-cost cases.

Health plans that have the option to assume financial risk and providing benefit packages to more than one eligibility group or population may accept catastrophic risk for one population but not another. Health plans cannot choose to accept catastrophic risk on an individual recipient basis, nor can they change the decision for a target population during a plan year. If a plan chooses not to cover the catastrophic component, the state will retain the catastrophic premium as a method to fund catastrophic coverage and maintain budget neutrality.

Based on preliminary analysis, the state expects that less than 10 percent of the aggregate premium will need to be allocated to the catastrophic care component. The actual portion of premium dedicated to the catastrophic component will depend on the established threshold level and plan cost sharing.

An individual's medical expenses become subject to catastrophic component funding when one of two defined thresholds is reached: dollar threshold or inpatient day threshold. The established thresholds may vary across populations (e.g., TANF vs aged and disabled) and across health plans as part of negotiations to bring in new managed care entities.

Dollar Threshold: All health care expenditures for each individual will be accumulated throughout the plan year and compared to a pre-established dollar threshold. If an individual's expenses exceed that threshold, the remainder of the expenses, excluding any required plan cost sharing, for that individual are provided through the catastrophic premium component, up to a maximum per-year benefit limit.

The state will establish the individual dollar threshold, which will be in effect for all enrollees of the plan. The dollar threshold is derived from the historical utilization analysis used to develop the comprehensive and catastrophic premiums. The methodology for deriving the dollar threshold will be based on high-cost claims analysis, the desired amount of the high-cost claims to be retained in the comprehensive premium component (i.e., plan cost sharing), and the desired percentage of medical expenses covered by the catastrophic component.

The maximum covered benefit level will be set at an extremely high level for all Medicaid Reform enrollees, and once this maximum benefit level is reached, further care for that individual becomes "uncompensated care" – which is similar to what happens in the current Medicaid program for certain high-cost procedures. For instance, the cost for transplants is currently set at a global rate, which typically is set below hospital cost. Any cost incurred by the hospital above the global rate is currently considered by the hospital to be uncompensated. While the individual dollar threshold will be the primary mechanism used to trigger catastrophic coverage, the state may use additional mechanisms to reduce the amount of risk retained by a managed care plan to the extent that such products are not available on the commercial market.

Inpatient Day Threshold: The current Medicaid State Plan limits Medicaid coverage of inpatient hospital days to 45 days per state fiscal year for individuals over age 21. It is possible that a customized benefit plan may include fewer covered inpatient hospital days, yet still meet the sufficiency test for certain target populations (see above for description of the sufficiency test). The state desires to provide up to 45 days of inpatient coverage regardless of the nominal limit established by the health plan, and those excess days will be funded through the catastrophic premium component.

The state intends to establish catastrophic dollar thresholds and inpatient sufficiency thresholds in such a manner as to make it highly unlikely that an individual would exhaust his covered inpatient days prior to reaching the catastrophic dollar threshold. However, to guard against the possibility that this could occur and cause a gap in coverage, the state will establish a separate inpatient day threshold that would trigger payment through the catastrophic premium component for inpatient care that occurs after covered days are used and prior to the dollar threshold being met.

Overall Maximum: The state will also establish an overall annual maximum benefit level. The maximum benefit limit will be applied to all reform recipients with the exception of children under age 21 and pregnant women. The actual annual limit will be established in conjunction with development of the premium components. The actual level will be sufficient to cover the needs of the vast majority of enrollees. The annual limit further bridges the gap to private insurance as aggregate limits are a common feature of most insurance policies. The annual aggregate limit will provide an opportunity to control maximum expenditures and thus impacts the premium development. This provides the state additional flexibility in structuring benefits for the target population as an alternative to the old method of creating specific limits for certain services. At the same time the annual aggregate maximum limit also provides a safeguard to enrollees as the annual limit will renew each year to cover additional services.

All health plans will be responsible for providing and coordinating all recipient benefits, regardless of whether those benefits are being funded through the comprehensive or catastrophic premium component and regardless of whether the plan has chosen to bear financial risk for catastrophic care. For those plans that do not accept financial risk, the state becomes the re-insurer, and the health care plan remits claims to the state for services rendered under this component. The move from comprehensive to catastrophic is seamless for the enrollee, and the enrollee does not know which health plans are at risk for the catastrophic component.

Safeguards

The state has carefully designed the comprehensive and catastrophic care components to minimize financial cost shifting and to maximize enrollee care. To ensure appropriate financial incentives and minimize cost shifting, the state will require the following:

State notification - Health plans must notify the state when they have paid claims reaching a specific amount, such as 50 percent of the catastrophic dollar threshold. This puts the state on notice that an individual may reach the dollar or inpatient day threshold during the fiscal year. This will also provide the state the opportunity to intervene, through utilization review or peer review, if appropriate, in the management of the delivery of care. The state may implement penalties if a health plan fails to properly notify the state.

Fee-for-service pricing - In keeping with the policy objective of the state to move from the role of centralized decision maker to that of health care purchaser, each health care plan will have the flexibility to reimburse its providers by the method of its choosing, and in the amounts of its choosing. However, the state was concerned that if the dollar threshold was based on health plan payment schedules, those health plans choosing not to accept risk for the catastrophic component would have less incentive to pay network providers efficiently for high cost cases. Under this scenario, the health plan could pay providers considerably more than market rates, yet still be protected from further financial loss because the catastrophic care component would step in at a defined amount.

To mitigate this possibility, each health plan will be required to maintain a shadow claims process whereby all claims are re-priced at the Medicaid fee schedule. An enrollee will reach the dollar threshold only when claims priced at the Medicaid fee schedule reach the threshold, regardless of the actual rates paid to network providers. Furthermore, "reinsurance" to the plan would be based only on the Medicaid fee schedule.

Health care plan co-insurance - For those health plans that choose not to accept risk for the catastrophic component, once an individual becomes eligible for the catastrophic component, the state will act as the re-insurer and will pay the catastrophic claims submitted by the health plan. The health plan continues to manage and coordinate care for the Medicaid enrollee. However, the state was concerned that there was not enough incentive for non-risk bearing plans to appropriately manage care after the threshold is reached. To ensure that there is adequate incentive for the plans to appropriately manage care once an individual gets close to the dollar or inpatient day threshold, the health care plan will be required to pay a co-insurance amount for each catastrophic claim and their on-going cost. At this point the state anticipates this co-insurance will be minimal and consistent with industry standards. Thus, once the threshold is crossed, the state pays bulk of (e.g. 90 to 95 percent) the catastrophic claim based on the Medicaid fee schedule, and the health plan pays the co-insurance (e.g. 5 to 10 percent) of the catastrophic claim along with any amount greater than the Medicaid fee schedule and its own provider reimbursement arrangement. The expected value of the plan coinsurance will be incorporated into the comprehensive premium component – this provides plans the financial incentive to manage the enrollee as they will keep the expected value of the coinsurance for individuals who do not enter into the catastrophic component.

Cost Sharing

Under Medicaid Reform, cost-sharing requirements consistent with the currently approved nominal levels in the State Plan may be imposed by managed care plans. Current cost-sharing, including co-payments and co-insurances, are as follows:

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

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

C. Enhanced Benefits

One of the more innovative components of the demonstration will be to create an Enhanced Benefits program for enrollees. The purpose of the Enhanced Benefit plan is to offer incentives to enrollees to participate in wellness activities. The program will provide a direct incentive to enrollees to take an active role in their health and further

the consumer driven model as they will have direct control over funds earned. The Enhanced Benefits plan will be funded through savings from the waiver. The state will set aside an aggregate amount to fund enhanced benefits for each enrollee into an Enhanced Benefit Account.

The Enhanced Benefit program is designed to maintain or improve the individual's health. Once an individual undertakes an approved activity, funds will be placed in an account for the enrollee's use. For purposes of drawing down federal match, the state will consider the money spent once it is placed in the enrollee's Enhanced Benefit Account. The state will establish a process to reconcile and recoup unspent funds, as outlined below. The process will include a return of the federal share of any amounts recouped.

The state will establish uniform statewide standards governing administration and access to accounts to ensure consistent and fair application. To ensure efficient and effective operation, the state will establish eligibility and participation requirements that will apply statewide to all enrollees. In addition, the state will develop an Enhanced Benefit Panel to oversee policy development and envisions contracting with an administrator to handle accounts.

1. Eligibility

All reform enrollees who select a reform managed care plan will be eligible to participate in the Enhanced Benefit program. The state and the managed care entities will provide information about participation in the enhanced benefits program.

The state will establish a list of activities that will generate contributions to the account. A menu of benefits or programs will be provided as will the individual value of each item on the menu. Individuals must earn eligibility to access these enhanced benefits by exercising personal responsibility and participating in established healthy practices. Therefore, the amount available to individuals from their enhanced benefit account will depend on the activities in which they participate up to a maximum amount. Once an enrollee completes an approved activity, the enrollee will be considered an active participant. The state will deposit earned funds into an account for use by the enrollee. Additional funds may be earned as the enrollee participates in additional activities. In no instance will the individual receive cash.

Enhanced benefits will be available to individuals even after Medicaid eligibility has ended. If an enrollee has funds in the Enhanced Benefit Account, when eligibility ends, the enrollee may still use funds in the account to purchase insurance, such as employer-sponsored insurance, COBRA or private insurance. Individuals with incomes less then 200 percent of the Federal Poverty Level (FPL) would retain access to funds for up to three years after a loss of eligibility.

If an individual subsequently regains Medicaid eligibility, the enrollee will be eligible to participate in the Enhanced Benefit plan and earn additional funds.

However, individuals will lose access to any unspent funds in the account if the individual's income exceeded 200 percent of Federal Poverty Level (FPL) or the funds are not spent within three years of loss of eligibility. If the individual does not use funds in the account after three years, the funds will be returned to the state. The state will establish a process to identify accounts that have been dormant for three years. The state will reconcile these accounts and recoup any unspent funds. The state will return the federal share of any refunds to CMS, as appropriate.

2. Enhanced Benefit Panel

The state will directly manage the development of policies and procedures that govern the Enhanced Benefit plan by establishing the Enhanced Benefit Panel.

The Agency will create a seven-member panel to guide in the development and evaluation of the Enhanced Benefit plan. The panel shall consist of the chair; three members of the Division of Medicaid; a patient advocate; a representative from the health plans; and an Agency Fraud and Abuse Representative. The Deputy Secretary for Medicaid or his or her designee will serve as the Chair. A patient advocate and the representative from the health plans will be appointed by the Secretary of the Agency for Health Care Administration (Agency).

The purpose of the panel will include, but not be limited to, the following duties:

- designate activities that may be beneficial to individuals;
- assess the benefit of a proposed activity to enrollees;
- establish appropriate earnings to incentivize participation;
- evaluate participation levels;
- identify qualified expenditures;
- evaluate expenditures; and
- oversee administration.

Examples of activities that the panel may consider are identified in Appendix V.

Eligible uses of the funds in an Enhanced Benefit Account will include qualified health-related expenditures and may include purchase of services not covered by the comprehensive plan, such as over-the-counter medications, or purchase of specialty service plans. Enrollees may accumulate funds for larger purchases, such as health-related home modifications. Enrollees may also purchase services from a managed care plan that provides an option to enrollees. For example, the enrollee could purchase over-the-counter medications from the managed care plan by mail order. This may be attractive to the enrollee since

the managed care plans have the ability to negotiate with providers and obtain volume discounts.

3. Enhanced Benefit Administrator

The state may contract with a centralized administrator to manage the Enhanced Benefits fund on behalf of all individuals, and each individual will have a separate account. The state will work with the centralized administrator to establish details of program operations. Individuals would not have access to cash, but would be aware of the amount in their accounts and how to access funds to pay for services and items.

Figure 1: Flow Chart of Administration of Enhanced Benefits Accounts

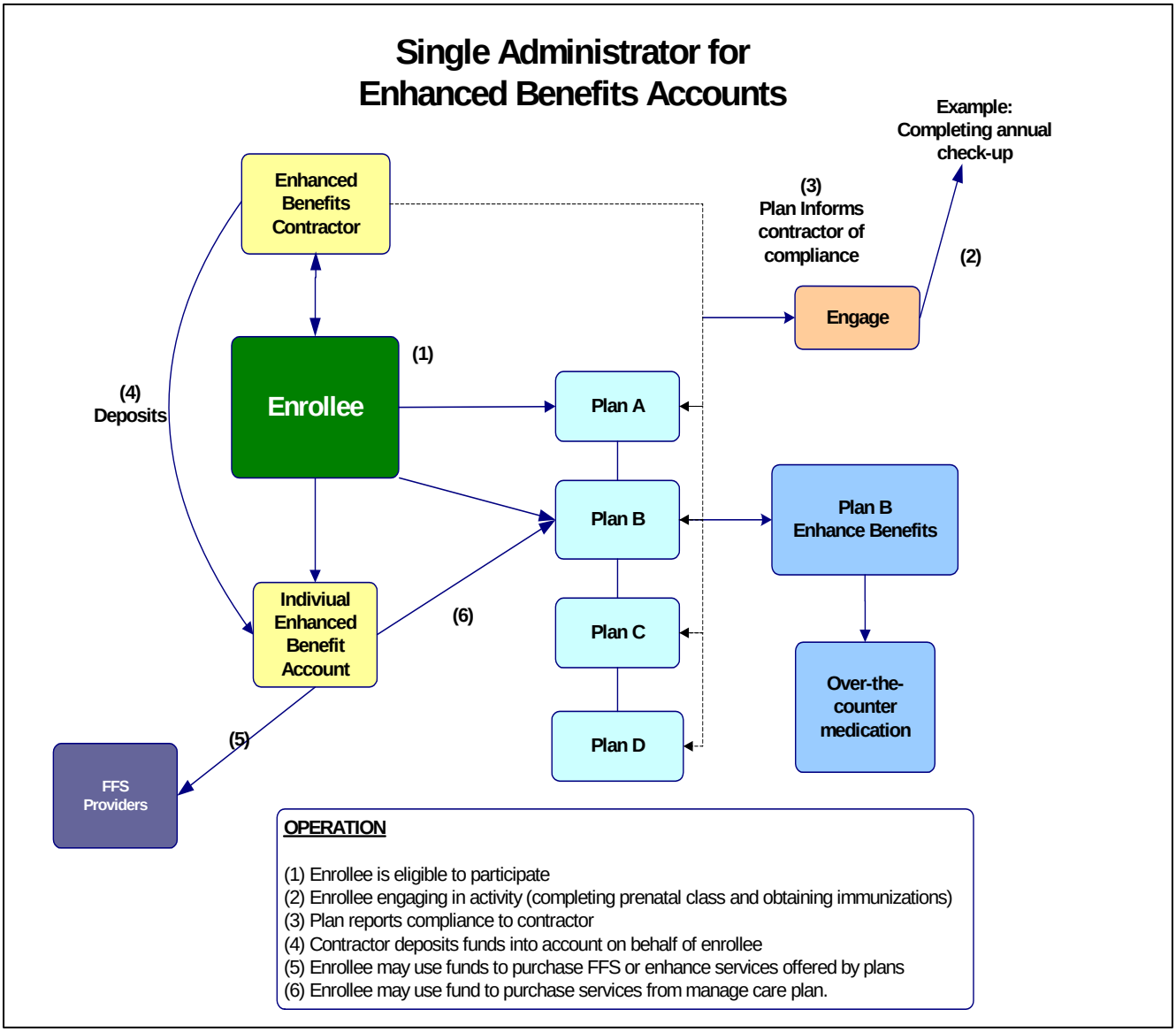


Figure1 provides an example of how the state envisions the overall operation of the program using a central administrator. Included in the chart is the managed care plan's involvement in providing information regarding an enrollee process. One of the advantages of having a central administrator is that the accounts will be maintained on behalf of the enrollee regardless of which managed care plan the enrollee selects. An enrollee who chooses to change plans still retains access to funds in the account.

V. Opt-Out: Employer Sponsored Insurance

Two key principles of Florida Medicaid Reform are patient empowerment and bridging public and private coverage. A primary mechanism to incorporate these principles into Medicaid is the ability of individuals to choose to opt out of Medicaid and obtain coverage through their employer-sponsored insurance (ESI) plan, or through a private plan if the individual is self-employed. Families that take advantage of ESI coverage are more likely to have the entire family covered under the same insurer, which increases the likelihood of continued coverage and the preventive behaviors that foster better health. Additionally, participating in coverage obtained through the workplace strengthens the tie to the workplace, further contributing to the goals of self-sufficiency and empowerment.

A. The ESI Environment in Florida

Under Section 1906 of the Social Security Act, a state may establish a Health Insurance Premium Payment (HIPP) program. Florida does not currently operate a HIPP as it is administratively burdensome. Specifically, HIPP programs require that the state continue to cover services not available under the ESI plan, pay all premiums and all cost-sharing amounts greater than requirements under Medicaid and that the program be cost-effective. The difficulty of obtaining information from employers regarding benefits and cost-sharing makes it administratively difficult to manage a HIPP while also ensuring cost-effectiveness.

The state believes that by permitting individuals to direct their premiums for use as a subsidy for the employee share of ESI, or as premium payment into a private plan when the individual is self-employed, that some individuals may choose this option. The state will provide strong outreach and education through the choice counselor to increase awareness and understanding of the opt-out program.

According to information from the Kaiser Family Foundation, in 2002, 42 percent of Florida firms with fewer than 50 employees offered health insurance to their employees, and 96.8 percent of Florida firms with 50 or more employees offered health insurance to their employees.[1] In addition, 53 percent of non-elderly Florida Medicaid households have at least one full-time worker, and ten percent have at least one part-time worker.[2] These figures indicate that many Florida Medicaid enrollees have access to private

[1] Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org: Florida: Health Coverage and the Uninsured. July 14, 2005.
[2] Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.org: Florida Distribution of Nonelderly Medicaid Enrollees by Employment Status, state data 2002-2003, U.S. 2003, July 14, 2005.

insurance. The opt-out program will provide enrollees with one more choice and increase participation in the private insurance market.

The State of Florida has legislation addressing minimum standards of coverage for the following insurance products:

- Individual Health Policies
- Group Health Policies and Small Group Plans
- HMO Contracts and Small Group Plans
- Out-of-State Group
- Standard and Basic (HMO and Insurance).

The specific mandated benefits vary according to insurance product. Appendix VI provides a matrix of the mandated benefits by product. While comparisons with the current Medicaid benefit package are not feasible because of the differences in baselines, the matrix is provided for further information.

While coverage by ESI programs may be more limited than Medicaid coverage, the state would like to offer individuals the option of alternative coverage. The state believes that regardless of differences in coverage, certain individuals will select private coverage when available.

B. Enrollment and Disenrollment

All individuals eligible for Medicaid Reform may voluntarily opt out. Coverage will include individuals who have access to a qualified ESI health plan, COBRA coverage, and coverage through a private plan when the enrollee is self-employed. Enrollment in the ESI option will occur in the same staggered manner as enrollment in managed care plans under Reform, with enrollees receiving plan and opt-out information at eligibility determination or redetermination, or at their annual open enrollment, whichever is sooner. For new eligibles, enrollees will be informed of the program at the time of eligibility determination and how to contact the choice counselor for additional information.

The choice counselor will assist the individual in making an informed choice about opt-out by highlighting information the individual will need to consider in order to make a fully informed choice. Individuals interested in opt-out will be encouraged to contact their employer and the state's contract administrator for the opt-out program for additional information. The choice counselor will collect information on whether the individual has access to health insurance. At a minimum, the choice counselor will encourage the individual to seek information on the available health insurance at work; when the individual can enroll; review of cost-sharing by the plan; information about preexisting condition clauses; whether individual or family coverage is available. The choice counselor will then refer the individual to the state's administrator, which will assist the individual in the opt-out process. Specifically, the administrator will contact the employer and verify available health insurance.

Individuals will be informed of their premium share to be used as a subsidy to pay the employee share of the ESI plan. The same 30-day choice window will also apply, as will the 90-day change window. Unlike the managed care option, however, enrollees may choose to opt-out of Medicaid at any time, even after the 90-day change window when they are otherwise locked in to a managed care plan under Medicaid reform. To encourage enrollment, the administrator may periodically contact individuals regarding opt-out. This outreach process will enhance awareness of the program and help ensure coordination with the employer's time frame for open enrollment and qualifying events.

This exception to the lock-in is made because individuals may be eligible for ESI at different points throughout the year, and at this time Florida does not have a statutory provision requiring ESI plans to consider Medicaid eligibility a qualifying event. In addition, participation in opt-out is completely voluntary.

An enrollee who chooses to opt out of Medicaid and enrolls in an ESI plan may have the same 90-day change period provided to all enrollees in a managed care plan. During this 90-day change period the enrollee may opt back into Medicaid and select a managed care plan. The 90-day change period may be limited by the employer to comport with the employer's open enrollment period. After 90 days, no further changes may be made until the individual's Medicaid open enrollment period, the next employer-sponsored open enrollment period, including qualifying events, or unless the enrollee no longer has access to employer-sponsored coverage.

C. Payment of Premium Share

Individuals choosing to participate in the ESI option will register with the state's contractor and will provide all pertinent employer information, including the amount of the employee contribution for the ESI plan. The state's contracted administrator will be responsible for contacting the employer to verify coverage information and establish payment of the employee's share of the premium. Payment will be made directly to the employer of record whenever possible. In the case of an enrollee that is self-insured and has private coverage, payment will be made directly to the insurer of record.

Maximum payment will be the Medicaid authorized premium. If the employee contribution for the ESI plan exceeds the Medicaid authorized premium, the enrollee will be responsible for paying the additional amount. If the employee contribution is less than the Medicaid authorized premium, the enrollee may use the remainder of the premium to purchase family coverage or purchase supplemental health insurance coverage offered by the employer. The state may limit payment for supplemental policies to ensure efficient use of premium dollars. The availability of supplemental policies may provide access to services not currently covered by Medicaid such as adult dental coverage.

To ensure budget neutrality, the total amount of all premiums, including any supplemental policies, is limited to the Medicaid authorized premium.

D. Benefits and Cost Sharing

The benefit package under the ESI plan must meet minimum state licensure standards, but may be more restrictive than Medicaid coverage. However, because participation is voluntary, and enrollees may switch to a Medicaid plan during the open enrollment period, the state will not provide wrap-around benefits with the exception of any funds accrued in the individual Enhanced Benefits Account.

Enrollees electing to opt-out will be responsible for paying the cost sharing requirements of the ESI plan, including deductibles, co-insurance and co-payments. Medicaid does not contract directly with these entities and does not have the ability to limit cost sharing. ESI cost sharing requirements may be higher than the cost sharing requirements under Medicaid. Since the enrollee has voluntarily chosen to participate in the ESI option, the state will not provide cost sharing or wrap around services.

VI. Delivery Systems

The state will contract with multiple managed care plans to provide services. Managed care plans include HMOs, Exclusive Provider Organizations (EPO), licensed health insurers, and Provider Service Networks (PSN). The state will reimburse most managed care plans on a capitated basis; however fee-for-service payments may be used for PSN providers for up to three years from the start date of implementation in an area.

As described in Section IV., Benefits, capitated managed care plans may create customized benefit packages that vary in amount, duration, and scope from State Plan services. Those PSN plans that continue to be paid on a FFS basis will not be permitted to vary the amount, duration or scope of services from that set out in historical Medicaid.

Below is a description of the provider types.

A. Entities Regulated under Florida Insurance Statutes

The Office of Insurance Regulation (OIR) in the Department of Financial Services regulates many of the managed care plans that will be paid on a capitated basis. Regulatory oversight includes monitoring the solvency of life and health insurers and managed care entities that are authorized to operate in the State of Florida. OIR reviews all new entities wishing to enter the Florida marketplace as well as any material changes in ownership of insurers domiciled in Florida. When an insurer violates solvency standards, OIR initiates a plan of action with the company to address the regulatory issue.

Managed care plans that are required to be licensed, risk-bearing entities may assume responsibility for both comprehensive and catastrophic care. In accordance with 42 CFR 438.2, comprehensive risk is defined as a managed care plan that is at-risk for inpatient hospital services and three or more mandatory State Plan services in section 1905(a). Any entity assuming risk and receiving capitation for the comprehensive or the comprehensive and catastrophic components will be considered a comprehensive risk-bearing entity in accordance with Federal requirements. As such, all managed care plans paid on a captitated basis will be required to meet state fiscal and solvency standards.

1. HMOs: Health Maintenance Organizations

   An HMO is an organization authorized under Chapter 641, Florida Statutes, that provides health care coverage on a prepaid per capita basis.

   As of July 2005, there were 32 licensed HMOs in Florida of which 12 are Medicaid HMOs and 15 are Medicare HMOs. In Duval County, Medicaid

contracts with one HMO. In Broward County, the state contracts with 7 Medicaid HMOs. Refer to Appendix I for a list of HMOs.

2. Licensed Insurers

The state may also contract with health insurers to enroll as Medicaid managed care plans and provide coverage to individuals. These providers will be required to meet state financial and solvency standards for insurers. The financial standards are specified in Chapter 624 of Florida Statutes and are generally greater than the standards required for HMOs. Health insurers may serve enrollees in Medicaid Reform with products such as:

- PPO: Preferred Provider Organization – A group of licensed health care providers, each of which has directly or indirectly contracted with the insurer for alternative or reduced rates of payment.
- POS: Point of Service – A provider or a group of providers of health care that offer individuals the option of receiving, care from an in-network or out-of-network provider at the point of service.
- EPO: Exclusive Provider Organization – A provider of health care or a group of providers that has entered into a written agreement to provide benefits under a health insurance policy. EPOs are not directly regulated as to solvency by the Office of Insurance Regulation but typically contract through another entity that is so regulated, such as an HMO or an Insurance Company.
- EPOs may, without going through an HMO or insurer, contract to offer their own providers' services on a capitated basis to self-insured benefit plans or to Medicaid. When operating in this manner, EPOs are comparable to PSNs (see below). The state does not currently have any Medicaid contracts with EPOs but is reviewing an EPO application.

The Agency will work with the Office of Insurance Regulation to determine appropriate solvency provisions for any EPOs it contracts with as part of Medicaid Reform.

B. Provider Service Networks

PSNs are networks established or organized and operated by a health care provider, or group of affiliated health care providers, which provide a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers. They may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the PSN.

In accordance with Section 409.912, Florida Statutes, the state may reimburse a PSN on either a fee-for-service or prepaid basis. Once capitated, all PSNs will be required to assume responsibility for comprehensive coverage and meet established solvency standards. Capitated PSNs are exempt from many of the regulatory provisions that apply to HMOs under parts I and III of Chapter 641, Florida Statutes, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the Agency. Once a PSN accepts capitation for the comprehensive benefit package it will be required to meet the following financial reserve requirements:

1. The entity shall maintain a minimum surplus in an amount that is the greater of $1 million or 1.5 percent of projected annual premiums.

2. In lieu of the requirements in subparagraph 1., the Agency may consider the following:

    a. If the organization is a public entity, the Agency may take under advisement a statement from the public entity that a county supports the managed care plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer, or oversee the managed care plan, either partly or wholly, through a county department or agency;
    b. The state guarantees the solvency of the organization;
    c. The organization is a federally qualified health center or is controlled by one or more federally qualified health centers and meets the solvency standards established by the state for such organization pursuant to s. 409.912(4)(c), Florida Statutes; or
    d. The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 C.F.R. ss. 422.380-422.390.

PSNs will have the option to assume responsibility for catastrophic coverage, but will be required to meet more stringent financial standards consistent with licensed HMOs in Chapter 641, F.S. and s. 409.912, F.S. Chapter 641 requires that an entity shall at all times maintain a minimum surplus in an amount that is greater of $1,500,000, or 10 percent of total liabilities, or 2 percent of total contract amount.

If the provider service network does not meet the solvency requirements of Chapter 641, Florida Statutes, the provider-sponsored network is limited to contracting with Medicaid.

In addition to review and approval of financial requirements, the Agency will require the PSN to meet network and quality of care standards consistent with managed care plans and in accordance with 42 CFR 438. The purpose of the certification process is to support and encourage innovation among the state’s community and safety net providers who may not be licensed as risk-bearing entities. PSNs may include community-based health care plans and safety net plans. These will likely be

collaborative partnerships with hospitals, health departments, federally qualified health centers, rural health centers, and local governments.

Currently, the state contracts with one PSN in Broward and Dade Counties. In addition, the state also contracts with several provider groups that may be able to qualify as PSNs in the demonstration areas. Specifically, the state contracts with 2 Minority Physician Networks (MPN) in Duval county and 2 MPNs and one Pediatric Emergency Room Diversion provider in Broward County.

C. Specialty Plans

In addition to, or in lieu of, providing the comprehensive and catastrophic care components of Medicaid Reform for a broad mix of enrollees, managed care plans will be encouraged to develop and offer specialty plans to serve individuals with specific conditions or select eligibility groups.

A specialty plan is defined as a plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs individuals and which has been approved by the state as a specialty plan. The state will approve specialty plans on a case-by-case basis using criteria that include appropriateness of the target population and the existence of clinical programs or special expertise to serve that target population. The state will not approve plans that discriminate against sicker members of a target population.

Specialty capitated managed care programs may focus on a population of individuals with chronic illnesses or specific diseases such as HIV/AIDS. SB 838 included the following requirement for special needs populations:

- **Children with Chronic Conditions** - develop and recommend a service delivery alternative for children having chronic medical conditions which establishes a medical home project to provide primary care services to this population.

- **Individuals with Developmental Disabilities** - develop and recommend service delivery mechanisms within capitated managed care plans to provide Medicaid services to persons with developmental disabilities sufficient to meet the medical, developmental, and emotional needs of these persons.

- **Children in Foster Care** – develop and recommend service delivery mechanisms within capitated-managed care plans to provide Medicaid services which must be coordinated with community-based care providers as specified in ss. 409.6175, Florida Statutes, where available, and be sufficient to meet the medical, developmental, and emotional needs of these children.

The state may also contract with Medicare Advantage Plans, designated as Special Needs Plans, to serve dual eligible enrollees, authorized by the Centers for Medicare and Medicaid Services.

In addition to financial reserve requirements and general network sufficiency requirements, the state will develop enhanced standards for specialty managed care plans that include but are not limited to:

- Appropriate integrated provider network of primary care physicians and specialists who are trained to provide services for a particular condition or population. The network should be an integrated network of primary care physicians (e.g., nephrologists for kidney disease; cardiologists for cardiac disease; infectious disease specialists and immunologists for HIV/AIDS).
- Network with sufficient capacity of board-certified specialists in the care and management of the disease for plans that seek to focus services for enrollees with a particular disease state. In addition, it is recognized that individuals have multiple diagnoses, and, therefore, the plan should have sufficient capacity of additional specialists to manage the different diagnoses.
- The plan should have a 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).
- Availability of specialty pharmacies, where appropriate.
- Availability of a range of community-based care options as alternatives to hospitalization and institutionalization.
- Clearly defined coordination of care component that links and shares information between and among the primary care provider, the specialists, and the family to appropriately manage co-morbidities.
- Use of evidence-based clinical guidelines in the management of the disorder.
- Development of a care plan and involvement of the family in the development and management of the care plan, as appropriate.

D. Employer-Sponsored Insurance (ESI)

Individuals who choose to opt out of Medicaid will be eligible to receive care from an employer-sponsored insurer. Coverage will include individuals who have access to a qualified ESI health plan and COBRA coverage. A qualified ESI plan will include the following:

- Large employer groups – Health insurance coverage provided by Florida-licensed insurers to businesses with more than 50 employees.
- Small employer groups – Health insurance coverage provided by Florida-licensed insurers to businesses with one to 50 employees.
- Employee Retirement Income Security Act (ERISA) plans – Employers establish these plans to provide health insurance. The employer may contract with an

insurance carrier to insure the plan or may opt for self-insurance. These plans are not regulated or licensed by the state.

E. Reimbursement

As authorized under SB 838, the Agency will develop actuarially sound, risk-adjusted premiums, separated into comprehensive and catastrophic components as well as an enhanced benefit that is not risk adjusted.

The premiums will be based on historical Medicaid expenditures, but will be appropriate for the various benefit packages that entities propose due to the requirement that those benefit packages be actuarially equivalent to historical Medicaid expenditures.

The Agency will reimburse some PSNs on a fee-for-service basis and all other managed care plans on the basis of the risk-adjusted capitation premiums discussed below.

Risk adjustment will be used to reflect differences in health status of enrollee and the overall risk profiles between the FFS and capitated populations and between the populations served by each managed care entity. This will help ensure budget neutrality and properly budget the proportion of expenditures that are anticipated to be attributable to the different payment methods and plans.

During implementation of the waiver, the premium rates will be based on 100 percent of historical Medicaid expenditures for mandatory and optional services, less any applicable discount. The state may adjust the expenditure levels allocated to the comprehensive and catastrophic care components to reflect anticipated incremental savings derived from a managed care environment. Total expenditures for the comprehensive and catastrophic components and the enhanced benefit will not exceed the limits established under the waiver.

1. Risk-Adjusted Capitation Premiums

As noted above, the Agency will develop risk-adjusted premium rates to pay the managed care entities.

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

Individual risk scores will be developed using fee-for-service and encounter data, as available; however, the Agency is aware that it does not currently have sufficient historical data on all enrollees to be used in the initial phase of

implementation. Therefore it is exploring alternative data sources such as pharmacy and inpatient data to identify appropriate sources to be used during the initial time period. The Agency will periodically update the individual's risk scores and the resulting risk-adjusted plan premiums to account for variations in service utilization and new enrollment into the plans. During the initial phase, the Agency will update risk scores more frequently to ensure that initial "unknown" risks become "known" risks in a timely manner. After the initial phase and when enrollment has stabilized, the Agency may revise the update process on a less frequent basis.

The managed care plans will be able to negotiate rates with providers. These rates may be based on a capitated methodology, fee-for-service, incentive-based, or any other fee arrangement that ensures accountability for services and expenditures. Negotiations must be done in good faith and may include any reimbursement method mutually agreed upon. The Agency will not interfere in contract negotiations, but will review provider subcontracts and require prior approval of any incentive programs to ensure that such programs are not in violation of federal requirements.

For certain events that may not be predicted in advance, such as pregnancy, the birth of a newborn, or high-cost cases for which there is a significant variance in historical expenditure (e.g. hemophilia), the state may develop special "kick payments" and/or high-cost claim pooling mechanisms.

The state assures CMS that premiums will be established in accordance with 42 CFR 438.6 and certified by an actuary.

The Centers for Medicare and Medicaid Services Regional Office will review and approve all capitation rates in accordance with 42 CFR 438, insofar as the requirement is applicable.

2. Fee-for-Service Reimbursement

The state may pay some or all PSNs on a fee-for-service (FFS) basis for up to three years, using historical Medicaid covered services with no variation of benefit package. The state will not reimburse a FFS-based PSN for services not authorized under the State Plan. The three-year limitation may include a saving settlement option for two years. PSNs may provide and directly pay for additional services through any savings earned.

The Agency will work with the actuary to develop guidelines for phasing in financial risk for PSNs over the three-year period. Any phase-in shall be converted to a risk-adjusted capitated premium after the third year.

In accordance with s. 409.912(44), Florida Statutes, the PSN will be cost-effective. Cost effectiveness will be measured to ensure that PSN per member,

per month costs are no greater than those associated with Medicaid capitated plans. Therefore, the PSN per member, per month expenditures will be evaluated against the risk-adjusted premiums to determine cost effectiveness. The comparison to risk-adjusted premiums will be similar to the process described above to develop individual risk adjustments.

F. Contracting Assurances

The state will select contractors in a manner consistent with the requirements under 45 CFR Part 74 and 45 CFR Part 95 if the contract value is over $100,000. The state intends to contract with all qualified plans on a continuous basis using an open application process to the maximum extent possible and allow all eligible providers to participate. In select areas, the state may limit the number of managed care plans in order to provide a sufficient number of enrollees to maintain efficient plan operations.

The state assures the Medicaid program integrity system will require each Medicaid managed care organization to comply with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The state will prohibit any of the Medicaid managed care organizations from knowingly having a relationship with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulations, of a person described above.

The prohibited relationships are:

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

G. Capacity Requirements

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

care providers sufficient in number, mix, and geographic distribution to meet the needs of the enrolled population. In addition, the numbers and types of providers available must consider the training and experience of specialized providers. Providers shall be available within reasonable travel and distance standards comparable to standards in the community as established by the Agency.

In evaluating adequacy of networks for managed care plans, the Agency will consider the demographics of a community and availability of services locally. In geographic areas where there are a large number of Medicaid recipients, the Agency will require managed care plans to demonstrate access to an adequate network of health care providers serving that community. Specific consideration will be given to areas considered economically depressed to ensure accessibility of services.

H. Grievance and Appeals

The state will develop and maintain a grievance process for Medicaid reform health care plans that:

- Requires each managed care organization to have an approved internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H and Subpart F Grievance System, in-so-far as these regulations are applicable.
- Establishes a state-level panel, which is consistent with the Subscriber Assistance Program in s. 408.7056 Florida Statutes, to hear appeals of grievances not resolved at the managed care organization level. The state-level panel will review grievances within the following timeframes:

    1. General grievances will be reviewed by the state panel within 120 days.
    2. Grievances that the state determines pose an immediate and serious threat to an enrollee's health will be reviewed by the state panel within 45 days.
    3. Grievances that the state determines relate to imminent and emergent jeopardy to the life of the enrollee will be review by the state panel within 24 hours.

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

    1. Informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
    2. Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if the state takes action without the advance notice and as required in accordance with state

policy consistent with fair hearings. The state must also inform enrollees of the procedures by which benefits can be continued or reinstated, and

3. Other requirements of fair hearing found in 42 CFR 4331, Subpart E.

For individuals electing to opt-out of Medicaid and use their premium to purchase employer-sponsored insurance or private insurance, the individual or subscriber may:

- Utilize the employer-sponsored insurance grievance process pursuant to Part III Health Care Services of Chapter 641, Florida Statutes, as applicable to HMOs and EPOs.
- Utilize the Subscriber Assistance Program pursuant to s. 408.7056, Florida Statutes, as applicable to HMOs and EPOs.

I. Program Integrity

The state's program integrity system will develop a process to oversee the activities of Medicaid managed care organization enrollees, health care providers, managed care organization networks, and their representatives in order to prevent fraud or abuse as defined in s. 409.913, Florida Statutes, over-utilization or duplicative utilization, underutilization or inappropriate denial of services, and neglect of enrollees and to recover overpayments as appropriate. The state will refer incidents of suspected fraud, abuse, over utilization and duplicative utilization, and underutilization or inappropriate denial of services to the appropriate regulatory agency, including the licensing agency and the Medicaid Fraud Control Unit of the Attorney General's office.

The program integrity system will require each Medicaid managed care organization to comply with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in-so-far as these regulations are applicable. The payments to each Medicaid managed care organization will be based on data submitted by the managed care organization and will be required to be in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

VII. Implementation Timeline

Florida's Medicaid Reform program will create an efficient and effective statewide delivery system that empowers patients while enhancing quality of care. As such, Medicaid Reform will ultimately impact virtually every aspect of Florida's current Medicaid program. Because of the magnitude of the changes, the state has adopted a measured approach to implementation, using a geographic and population phase-in. Implementation and expansion are contingent upon Legislative approval.

In SB 838 the Florida Legislature authorizes the Agency to seek a demonstration project waiver, pursuant to s. 1115 of the Social Security Act, to create a statewide initiative to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Florida Medicaid program. Medicaid Reform will create programs that center on care coordination, align financial incentives, and provide direct incentives to individuals to take an active role in their own health care.

This legislation contains specific requirements regarding implementation phases and necessary legislative approval. As specified in SB 838, the state will initially implement Medicaid Reform in two counties: Broward and Duval. It is expected that these two counties will become operational in the fourth quarter of SFY 2006, April - June, 2006. Within a year of implementation in Duval County, Reform will expand to include three contiguous counties to Duval County: Baker, Clay and Nassau Counties. The state will comply with all statutory requirements regarding expansion of the program and will expand only as authorized by the Legislature.

In addition, as outlined in Section III, certain populations will be mandated to participate in Reform while other populations will have the option to voluntarily choose to participate in Reform. At later stages of implementation, these voluntary populations, and others not yet included, will also be mandated to participate in Reform.

Upon full implementation, Medicaid Reform will serve the vast majority of Medicaid enrollees, including:

- TANF and TANF-related enrollees;
- aged and disabled enrollees;
- enrollees residing in nursing homes and other institutional settings;
- enrollees receiving hospice services;
- enrollees receiving sub-acute inpatient psychiatric services; and
- dual-eligibles.

Medicaid Reform will be the state's primary delivery system, with only a few groups of recipients continuing in the fee-for-service delivery system. Fee-for-service will be limited to groups such as the Medically Needy and those with retroactive eligibility.

This implementation timeline provides an outline of pre-implementation activities, the initial phases of implementation, and consideration for future expansion. Any expansion beyond the initial phase-in must be approved by the Florida Legislature. Through on-going coordination and reporting, CMS will be notified in advance as additional phases proceed.

A. Pre-Implementation

The Agency will be the administering agency responsible for the daily operation and management of Medicaid Reform, including all phases of implementation. Prior to the initial implementation, the state will establish a transition team to evaluate current processes and develop an implementation plan. The mission of the team will be to conduct a "redundancy and collapse" analysis. Specifically, the team will evaluate current programs, identify core delivery systems, evaluate operational functions and assess how to integrate them into the new service delivery. The focus is to collapse core functions into a single operational process to eliminate any potential disruption in operation and provide a seamless transition. Integral to this process will also be an evaluation of gaps in processes for which the state must create new functions. Specific functional areas that the state will focus on include: procurement of plans, plan readiness, eligibility and enrollment, outreach and education, and payment systems.

1. Procurement of Plans

The state will employ an open application process, develop application standards, and create an evaluation protocol (see Appendix IV). The state envisions using an open application process for both the capitated managed care plans and PSNs. Under the open application process any plan that meets the established requirements and standards will be permitted to participate, unless the state has determined that additional plans would over saturate the marketplace. This approach will foster the greatest number of plan choices for enrollees, while preventing any implementation disruptions that can be caused by procurement protests.

The state will establish evaluation teams to review and approve plan applications. Review teams may include individuals with the following expertise:

- Health Care Delivery (Physician, Registered Nurse)
- Medicaid Policy
- Enrollment
- Claims Processing
- Actuary (optional)

For the standard requirements, the state will at a minimum review: applicable licensure requirements; financial solvency; proposed customized benefit

packages, including cost sharing; authorization systems; claims processing capabilities; provider networks; quality assurance protocols; utilization management and care coordination processes; enrollee materials; program integrity requirements; and the grievance and appeals process. HMOs and other licensed insurers will need to obtain state licensure, including a certificate of authority for operation, prior to submitting an application. PSNs will be required to meet state established standards prior to contracting.

Those capitated managed care plans and PSNs that meet the standard requirements in each of the above areas, in addition to other criteria that may be established, will be approved to participate in Medicaid Reform.

2. Plan Readiness Review

The state evaluation teams will also conduct plan readiness reviews. These readiness reviews will have two elements: desk review and on-site review. The desk review will include a final check on all documents and protocols the plans will be using, such as member handbooks, provider directories, quality assurance protocols, financial reporting protocols, etc. The evaluation teams will also conduct thorough on-site reviews to ensure that each plan is capable of fulfilling all state and federal requirements, and is ready for operations. This on-site review will include assessments of operational capacity, such as member and provider services departments, including call centers; network verification; systems and claims processing testing; program integrity processes; and quality assurance processes. Once a plan has passed all elements of the desk review and on-site review, it will be permitted to participate in Medicaid Reform.

3. Eligibility and Enrollment

The state will evaluate all eligibility and enrollment processes to ensure that clear, correct, and timely information is available to individuals. To accomplish this, the Agency will work with its sister agency, the DCF, which is responsible for determining eligibility for Medicaid. Since eligibility will remain unchanged, the state will focus on coordination of information so current and pending Medicaid enrollees may access information from the choice counselor as soon as possible. The Agency and DCF will also work together to ensure that information is properly conveyed about plan selection during the recipient redetermination process.

As discussed in Section III, the state will contract with a choice counselor to develop and disseminate information to assist individuals in making their plan choices. The state will assess additional information needed to explain managed care plans and may supplement materials with consumer satisfaction data, quality data, medical loss ratio, and other pertinent information. A central focus will be evaluating the logistics of providing

information to applicants during the eligiblity redetermination process so they understand how to enroll in a plan.

4. Outreach and Education

An outreach and education team will be established to develop strategies separate from the choice counseling function. The primary purpose of this outreach effort is to facilitate a smooth transition to Reform by ensuring that all affected individuals are informed of changes and potential impacts. The team will assess all current outreach strategies to identify needed changes and additional information needed related to reform. The state will conduct outreach to providers, advocates, other agencies, current and potential Medicaid enrollees, and other stakeholders. To accomplish this, the state will partner with community providers, including small businesses, to provide increased awareness of Medicaid Reform. The 11 Medicaid Area Offices will serve as a point of contact to coordinate local efforts. The state assures that enrollee information to potential enrollees and enrollee will meet requirements under Section 1932(a)(5), Provision of Information.

5. Payment Systems

In addition to the above teams, the state will create a payment team to focus on the development of risk-adjusted premiums paid to capitated entities. Premiums will be developed using a methodology consistent with 42 CFR 438.6 and risk adjusted according to established criteria. In addition, all premiums will be certified as actuarially sound.

The state will develop a transition plan for PSNs paid on a fee-for-service basis to move to a risk-based reimbursement system within three years of implementation. The state will identify, plan, and modify information systems as needed in order to pay the plans. The state is reviewing the Florida MMIS and assessing needed programming changes.

B. Implementation of Phase I

The state anticipates that the first phase of implementation will begin during April-June, 2006. As indicated above, this first phase will include two diverse geographic areas – Duval and Broward Counties. Within one year of implementation, by June 2007, the Duval area will be expanded to include Baker, Clay and Nassau counties. (See Figure 2 on page 52.)

1. County Characteristics

Broward and Duval Counties are significantly different in terms of population and current managed care penetration. For example, the 2003 population estimates for Broward County, which includes the Metropolitan Statistical

Area (MSA) of Ft. Lauderdale, is 1,731,347, compared to 817,480 in Duval County, which includes the MSA of Jacksonville.[3] As of June 2005, there were 196,333 Medicaid recipients in Broward County of which 136,380 were enrolled in a managed care option and 108,231 in Duval County of which 79,046 were enrolled in a managed care option. Current Medicaid managed care choices differ significantly as well, with Broward County offering seven HMOs (in addition to MediPass, PSNs, and Minority Provider Networks [MPNs]), compared to Duval County with only one HMO (in addition to MediPass and MPNs).

The second stage of Phase I implementation, the addition of Baker, Clay and Nassau Counties, adds a rural component to the Duval area. Population estimates for 2003 for these counties are: Baker – 23,424; Clay – 157,502, and Nassau – 61,625. In addition, managed care penetration is very low in these counties with only a MediPass option. (See Appendix I for a complete chart of commercial, Medicaid, and Medicare managed care penetration, by county.)

Statewide, as of June 2005, Medicaid contracted with one PSN, two MPNs, one Emergency Room diversion program, and eleven HMOs. The number of managed care plans available in an area varied. The total Medicaid managed care enrollment, including MediPass, in the two initial counties as of June 2005 is a follows:

Table 1: Current Managed Care Enrollment in the Demonstration Area

Duval County	Providers	Total	SSI	TANF	%SSI
HMO	1	41,418	5334	36084	12.9%
MediPass		32,880	7,476	25,404	22.7%
Minority Physician Network	1	3,826	689	3,137	18.0%
		79,046	14,062	64,984	17.8%

Broward County	Providers	Total	SSI	TANF	%SSI
HMO	7	74,121	9,866	64,255	13.3%
MediPass		25,063	5,346	19,717	21.3%
Provider Service Network	1	6,343	1,565	4,778	24.7%
Minority Physician Network	2	12,365	2,658	9,707	21.5%
Pediatric Associates	1	16,173	689	15,484	4.3%
		136,380	21,469	114,911	15.7%

The differences in demographic and managed care characteristics for the two counties will provide unique opportunities as well as challenges. The state believes that by implementing Phase I in these areas, it will have a solid base

[3] U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/12/12011.html, July 28, 2005

on which to shape further expansion and evaluate the success of Medicaid Reform.

2. Delivery System

All current managed care providers, including HMOs, PSNs, MPNs, and the ER Diversion program, will be required to apply as reform plan in order to continue participation in the demonstration sites. The state anticipates that all managed care plans will continue to participate and that there will be new plans in each area. Based on this assumption, Duval is expected to have at least two managed care plans and Broward is expected to grow to 11 managed care plans. A plan must serve the entire county. When the state expands the Duval site, plans seeking to provide services in multiple counties within an area may be required to offer services in a contiguous manner in order to prevent any gaps in coverage.

The state will also develop recommendations for serving children in foster care, those with chronic conditions participating in Children's Medical Services, and individuals with developmental disabilities. (See Section III.) During Phase I, the state will work with the Department of Health to establish a plan for children with chronic conditions. To the maximum extent possible, the program will be initiated in Duval and Broward. Once established, reform enrollment in demonstration areas will be mandatory. However, should it be determined that a statewide program is needed in order to provide for economies of scale and administrative efficiencies, the Agency recommends that a specialized plan be created as allowed under current statutory authority in s. 409.9126, Florida Statues, which authorizes a capitated program for Children's Medical Services. Elements of reform, however, such as the enhanced benefit and catastrophic component, may be limited to authorized reform areas until expansion is authorized by the Legislature.

Appendix II provides a detailed summary of the anticipated transition from current managed care plans to the new reform options. The figures provided are the Agency's best estimates based on certain assumptions. If actual experience does not match the assumptions, the estimated impact will need to be revised. As indicated in the summary in Appendix II, it is envisioned that all current MediPass and HMO enrollees will transition to a managed care plan under reform within 12 months.

As indicated in Section III, during the initial implementation some eligibility groups will be mandated to participate in Reform, while other groups may voluntarily choose a reform plan. The mandatory groups are TANF and TANF-related eligibles and the aged and disabled group. These groups were chosen because they are currently mandated to enroll in managed care plans. The Duval and Broward sites will initially enroll all individuals in the mandatory categories on a staggered basis. Stage 2 of the Phase I roll-out,

the three counties surrounding the Duval County area, will also enroll all individuals in the mandatory categories on a staggered basis. Full implementation of Phase I is expected to be complete by June 2008.

C. Implementation of Phase II

As indicated above, SB 838 requires legislative authorization for expansion of the demonstration project. The state will begin preliminary assessments on availability of plans, variation of plans, voluntary selection rates, consumer satisfaction and perform on-site reviews of the plans authorized in Phase I. This information will be available to the Legislature, and once the Agency receives approval, it will initiate implementation in additional geographic areas of the state.

To prepare for Phase II implementation, the state will collect information throughout the roll-out of Phase I. This will inform the state of any barriers experienced and lessons learned from the initial implementation. The state will conduct a preliminary assessment on availability of plans, variation of plans, voluntary selection rates, and consumer satisfaction. The state will also conduct on-site monitoring and review of the plans, concentrating on the standard elements of the initial application and readiness review. Additionally, the state will include in these assessments information obtained from the case studies and qualitative analysis of managed care plans, as outlined in Section IX.

Building on this information, the state will modify and refine processes developed during Phase I, as necessary, to ensure that program goals are accomplished. Such processes include the managed care plan application process; eligibility and enrollment information and processes, including the staggered transition process; and information and processes used by the choice counselor.

In addition to refining processes established in Phase I, the state will evaluate and identify geographic areas of the state to establish their readiness for expansion. Criteria for expansion may include:

Availability of managed care plans – The Agency will identify areas in which more than one managed care plan operates. For purposes of this identification this will include HMOs, EPOs, PSNs, MPNs, and ER diversion programs. The presence of a managed care plan will serve as a preliminary indicator of readiness for Reform expansion. As of July 2005 there were 33 counties with HMOs and 38 counties with another type of managed care program. Counties with some managed care penetration will likely be targeted for stage one of the Phase II implementation.

Interest by community and providers – The Agency will also continue to work with providers in communities that express interest in developing a PSN or HMO in areas where one does not currently exist. Under authority in s. 409.912, Florida Statutes, the Agency will continue to enter into contracts with these

entities. The Agency may enter into new agreements and pay risk-adjusted capitated rates for all currently covered Medicaid services. This would facilitate the development of specialty networks that may provide services on a statewide basis.

The Agency will also determine interest among prospective plans to participate under principles of Reform. Specifically, this will include assessing an entity's interest in development of a customized benefit plan, payment and separation of catastrophic risk.

The preliminary fact finding and evaluation of Phase I roll-out will occur during the second year of operation, and will be complete by June 2008. This information will be available to the Legislature, and, once the Agency receives approval, it will initiate implementation in additional geographic areas of the state.

D. Implementation of Phase III

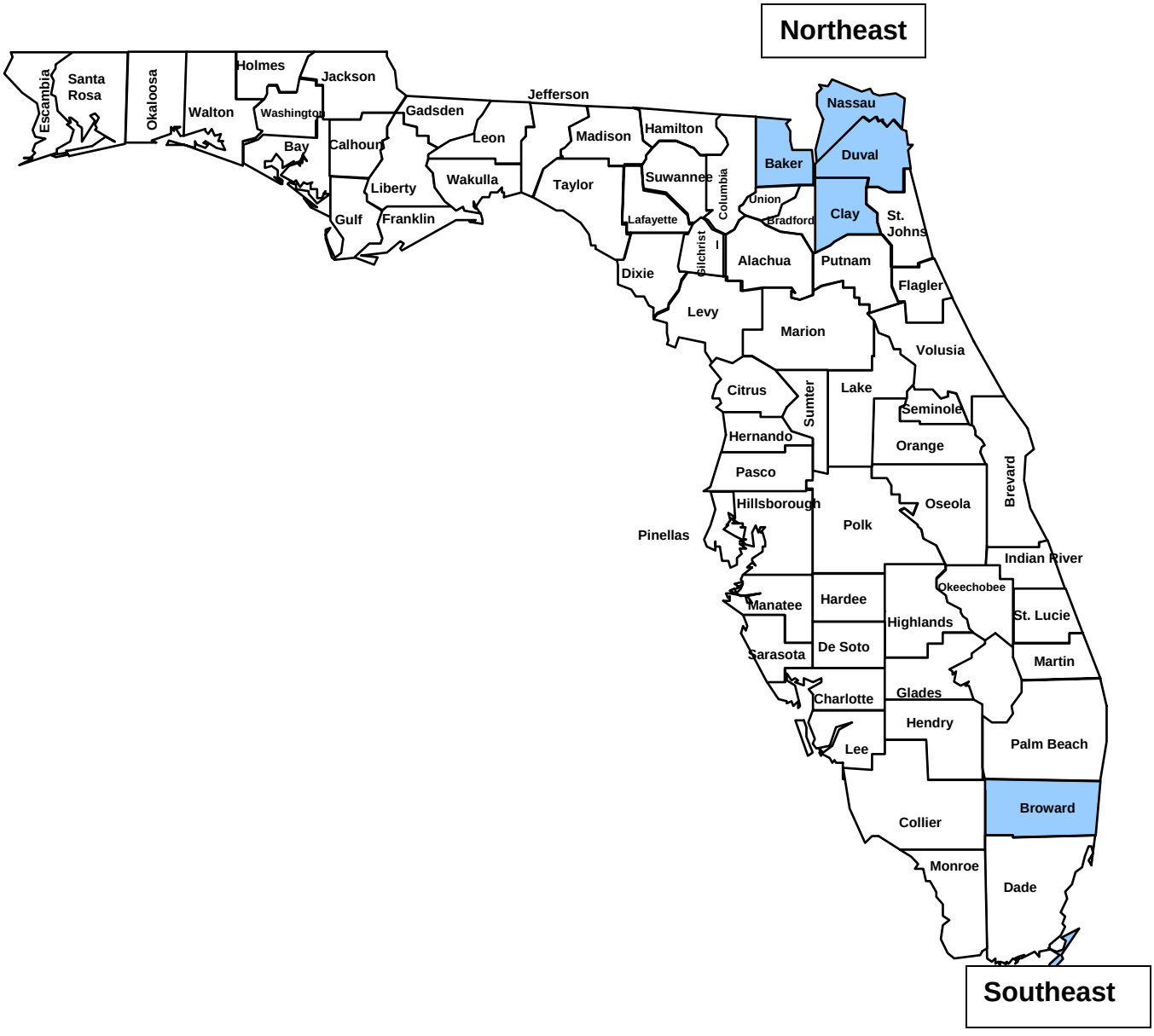
Implementation of Phase III will occur over the course of the following two state fiscal years, with near or full geographic implementation of Medicaid Reform expected by June 2010. Phase III geographic expansion is targeted to culminate in Medicaid Reform plans being operational statewide. This will be accomplished in stages, again with mandatory and voluntary populations enrolled on a staggered basis.

The fourth and final phase of Medicaid Reform implementation will occur once the geographic implementation is complete. This phase consists of expanding Reform to additional populations, specifically by mandating the enrollment of those population groups previously enrolled voluntarily. The area-by-area roll out of each population may be different for different population groups, depending upon the availability of fully developed networks. The state will carefully review the outcomes of the managed care plans in each area and will evaluate the readiness of each area to assume care for these populations on a mandatory basis. Enrollment may be limited to those areas that were fully implemented by the end of Phase II, thus enabling those with the most experience under Reform principles to be the initial sites for population expansion. The transition of these populations will also be on a staggered basis.

In addition, by Phase III the state expects that the special care networks for children with chronic conditions will be fully developed beyond the Broward and Duval areas, either on a limited or statewide basis. Enrollment of these children will become mandatory in those areas with such networks.

As each implementation phase progresses, the state will conduct ongoing analyses and evaluations to enable continuing program and process refinement. As a result each phase will build upon the strengths of previous phases, and identified weaknesses will be identified and rectified.

Figure 2:
Phase I



VIII. Accountability and Monitoring

The state anticipates continuation and enhancement of current monitoring activities. This section outlines various methods the Agency will use to ensure the delivery of high quality health care by all managed care plans to enrollees. The goal of the quality strategy is to promote the health and well being of enrollees by 1) assuring enrollee access to services; 2) holding managed care plans accountable for outcomes; and 3) promoting quality and cost-effective delivery of services.

A. Quality Strategy

Oversight will exist on two levels: at the Agency and at individual managed care plans. The Agency will have a written strategy for assessing and improving the quality and appropriateness of care delivered by all managed care plans to their enrollees. The quality strategy includes review of:

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

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

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

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

B. Grievance System

The state assures CMS that it complies with section 1932(b)(4) of the Act 42 CFR 438.400, Grievance Systems. All plans, except employer-sponsored or private plans serving individuals who opt out, shall establish a grievance system to assist all enrollees and providers who are dissatisfied. The grievance system shall comprise a grievance process, appeals process, and access to the Medicaid fair hearing system.

Individuals enrolled in an HMO also have the ability to file an appeal with the state's Subscriber Assistance Panel after exhausting the plan's internal grievance or appeal process. The panel reviews complaints against all HMOs, including those covered through employer-sponsored or private plans. However, the Subscriber Assistance Panel will not accept a grievance or appeal that has already gone through a Medicaid fair hearing.

C. Employer-Sponsored Insurance

Individuals opting out of Medicaid will receive services directly from an employer-sponsored plan or private insurer. These entities will not have a contract directly with Medicaid. Therefore, the state will rely on monitoring efforts conducted by the Florida Office of Insurance Regulation.

IX. Evaluation

Medicaid Reform will fundamentally change the current Florida Medicaid program. As such, the state is very interested in evaluating the impact of Reform and anticipates using the information obtained from the evaluation as a means to inform policy decisions in both the short and long term. The state intends to gather lessons learned on an incremental basis to shape further geographic expansion within the five-year demonstration, as well as evaluate the impact of the full five-year implementation.

The state has identified overall evaluation objectives, key research questions and hypotheses, data sources, and methodologies that can serve as a framework for the evaluation. In addition, an evaluation oversight committee will be established to provide ongoing guidance for the evaluation.

A. Evaluation Objectives

The key design elements of Florida's Medicaid Reform provide the state and CMS with an opportunity to implement and evaluate innovative and market-driven approaches to modernizing Medicaid. Through mandatory enrollment into managed care plans that offer customized benefit packages and the emphasis on individual involvement in selecting private health plan options, the state expects to gain valuable information about the effects of infusing market-based approaches with a public entitlement program. In keeping with this, the five evaluation objectives identified by the state are:

1. To evaluate the establishment of a competitive market-place environment as demonstrated by: a) an increase in the number of plans from which an individual may choose; b) an increase in the different types of plans; and c) increased patient satisfaction.

2. To evaluate the performance of managed care plans in relation to the needs of individuals as demonstrated by: a) increased access to services not previously covered; b) improved outcome measures based on HEDIS or HEDIS-like measures; c) timely access to specialists; and d) decreased utilization of emergency room care.

3. To evaluate the impact of reform on enrollee outcomes as demonstrated by: a) changes in the overall health status of enrollees; b) changes in ambulatory sensitive hospitalizations; and patient satisfaction measures.

4. To evaluate effectiveness of the bridge to independence as demonstrated by: a) the level of participation; b) patient satisfaction; and c) duration of enrollment in the employer-sponsored plan.

5. To evaluate the impact of the low-income pool on increased access for uninsured individuals.

B. Research Questions/Hypotheses

Medicaid Reform will impact key areas of the Florida Medicaid program: Patient Involvement, Access to Care, Quality of Care, Cost Containment, and Coverage. The research questions and hypotheses are presented according to each program area.

1. Patient Involvement

Research Questions

- What is the rate of active selection of health plans?
- What are the characteristics of individuals who choose to opt-out?
- What are the auto-assignment rates?
- What is the rate of plan changes during the 90-day disenrollment window?
- What is the level of patient participation in preventive health care services and healthy behaviors?
- What is the utilization of Enhanced Benefit Accounts?
- What are the characteristics of individuals who receive services through the low-income pool?

Hypotheses

It is expected that:

- The rate of enrollee choice of a plan will increase; auto-assignment rates will decrease (compared to counties with managed care currently).
- The percentage of plan disenrollments to another plan during the 90-day window will decrease (compared to counties with managed care currently).
- The percentage of reform enrollees who participate in healthy behaviors to earn Enhanced Benefit Account rewards will continue to increase on an incremental basis over the five-year period.

2. Access to Care

Research Questions

- What is the number, type, and distribution of health plans participating in Medicaid?
- Will a variety of health care plans participate in rural areas?
- Are services accessible to enrollees?
- When provided the opportunity, do plans provide additional services not covered by Medicaid? If so, what types of services?
- What is the participation in employer-sponsored insurance by Medicaid enrollees with access to ESI when compared to participation levels in similar Medicaid programs in other states?

Hypotheses

It is expected that:

- The number of health plans participating in Medicaid will increase and specialty health plans will develop to serve the needs of specific individuals.
- The benefit packages will vary and offer services not currently covered by Medicaid.
- Enrollees voluntarily selecting customized benefit packages will exceed the percentage that voluntarily selected MediPass in the year before program implementation.
- Increased choices in rural areas will result in reduced health disparities among select minority enrollees for specific health conditions in rural areas.
- The rate of disenrollment for opt-out during the 90-day disenrollment period for individuals who have opted-out will be less than rate of disenrollment for Medicaid plans.
- The number of enrollees under Medicaid Reform who are insured through private health coverage (ESI or other private coverage) in the year after losing Medicaid will increase.

3. Quality of Care

Research Questions

- Will the overall health status of reform enrollees improve?
- Will the percentage of enrollees meeting a catastrophic threshold remain constant or decline?
- Will enrollee satisfaction with the quality of care improve?
- Will health status improve for the target populations when compared to a similar population that is not enrolled in a specialty network?
- Will Enhanced Benefit Accounts promote preventive services and healthy behaviors?

Hypotheses

It is expected that:

- The percent of enrollees who meet catastrophic thresholds will remain constant or will be reduced.
- Client satisfaction with access and quality as measured by Consumer Assessment of Health Plan Survey will increase.
- Utilization of select preventative services and engagement in healthy activities will increase.
- Health disparities will be reduced among select minority enrollees under reform for specific health conditions.
- When measured against HEDIS standards, plan performance will be comparable to private plans.

4. Cost Containment

Research Questions

- Will increased enrollee involvement in health care decisions result in decreased emergency room care and prevent ambulatory sensitive hospitalization for select services?
- Will transition to capitated managed care plans contain cost growth over the five-year demonstration period?
- Do the financial safeguards developed for the management of catastrophic component provide incentive to manage care?
- Will the opt-out option reduce Medicaid expenditures associated with the participating population?

Hypotheses:

It is expected that:

- Increased enrollee involvement and health literacy will result in service utilization patterns reflecting a more cost effective use of services.
- Over the next five years, per enrollee cost by eligibility group will be less than the current program projected growth.
- Premiums paid on behalf of individuals will provide the state with per member per month savings when compared to the premium available under the opt-out option.

5. Coverage

Research Questions

- What is the impact of the Low-Income Pool funding on access for select services for the uninsured in catchment areas of the participating facilities?
- Does the ability to cover additional service result in increased enrollee satisfaction?
- Do plans offer more services than available under Medicaid FFS? If so, what services are most commonly covered?

Hypotheses

- The availability of funds through the Low-Income Pool will increase access for select services for the uninsured in catchment areas of the participating facilities.
- Plans that focus on specific populations (eg. chronic conditions or minority populations) will offer additional services not covered under Medicaid in an effort to reduce any associated health disparity.
- Individuals will be more satisfied with their health plan selection and the customized benefit package when compared to areas without customized benefit packages.

C. Data Sources

Data for the evaluation will be obtained from the following sources:

- Administrative data submitted during plan approval,
- Enrollment files,
- Encounter/utilization data,
- Audited HEDIS and HEDIS-like reports from participating plans,

- Consumer Assessment of Health Plan Survey (CAHPS) of a sample of each plan's enrollees supplemented by questions related to health status or special needs and experience with plan selection and Enhanced Benefit accounts, and
- Surveys of Medicaid disenrollees.

D. Methodologies

Various methodologies may be used to answer the research questions and address the hypotheses. The state expects to conduct both quantitative analyses and qualitative analyses. The state is considering a pre-post evaluation design for several areas since baseline data for many of the measures are currently available through the Consumer Assessment of Health Plan Survey (CAHPS), and Health Plan Employer and Data Information Set (HEDIS) and HEDIS-like measures currently used by the state, as well as current claims data. After the first two full years of implementation the state also anticipates that encounter data from the managed care plans will be available to use for program and evaluation purposes

A qualitative analysis will be conducted of participating managed care plans. As part of this analysis, managed care plans will be classified by selected variables such as type (HMO, PPO, safety net provider), benefit package offered, and provider network. Enrollment by plan and demographic profile of each participating managed care plan's Medicaid enrollees will be provided. Service utilization and selected outcome measures will also be provided by managed care plans.

Additionally, the state expects to employ a process analysis to gather lessons learned from initial implementation, as well as case studies on selected areas.

X. Title XIX Waivers

The state will be requesting that CMS grant a waiver of the statutory provisions identified below in order to effectively implement the Florida Medicaid Reform waiver.

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

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

2. Section 1902(a)(10)(B), Amount, Duration and Scope/Comparability of Services

   To permit the state to modify the Medicaid benefit package to allow for the creation of multiple benefit packages and specialty plans that offer differing benefits and benefits that vary in amount, duration, and scope, based on differing managed care arrangements, or in the absence of managed care arrangements. All benefit packages will be actuarially equivalent to State Plan coverage.

   To permit coverage of benefits for the demonstration population that is not covered for the non-demonstration population.

   To relieve the state of the requirement to provide wrap-around services for enrollees that choose to access coverage under an employer-based or private plan.

3. Section 1902(a)(10)C)(1), Income and Resource Rule

   To permit the state to exclude funds in an enhanced benefits account form the income and resource limits established under state and federal law for Medicaid eligibility. Recipients will be permitted to accumulate funds in an Enhanced Benefit Account for health-related purchases.

4. Section 1902(a)(14), Cost-Sharing

   To permit the state to authorize coverage of employer-based or private plans that have cost sharing requirements in excess of the Medicaid limits

5. Section 1902(a)(23), Freedom of Choice

   To enable the state to restrict freedom of choice of providers.

6. Section 1902(a)(32), Direct Payment

   To enable the state to provide the following:

   A direct payment to providers not enrolled in Medicaid on behalf of beneficiaries or their representatives for authorized medical-related expenditures under an enhanced benefit account.

   A direct subsidy or reimbursement, not to exceed the established premium, including through use of a voucher, to enrollees, or insurers to enable low-income enrollees to pay for their share of medical insurance costs when they elect enrollment in an available employer-based or private plan.

   A direct subsidy or reimbursement, including through a use of a voucher, to self-employed enrollees, or to insurers to enable enrollees to pay for the cost of health insurance.

7. Section 1902(a)(43)(A), Early and Periodic Screening, Diagnosis, and Treatment

   To waive requirements that the state must pay for any service required to treat a condition identified during EPSDT screening when the enrollee has opted out of Medicaid and enrolled in an employer-sponsored insurance or private plan that may not cover the service.

8. Section 1902(a)(3), Hearing Rights

   To waive the provision regarding hearing rights before a state Medicaid agency for the denial of a service by an employer-sponsored or private plan. Under Florida law, some individuals may access the state's Subscriber Assistance Panel, but provisions are not consistent with Medicaid fair hearing standards and do not apply to self-insured plans.

9. Section 1902(a)(8), Timely Processing of Applications

   To waive the provision regarding timely processing of applications to allow completion of the eligibility determination contingent upon the individual selecting, or the state assigning an individual to, a managed care plan within the first 30-days. During this period, the individual will receive only emergency care.

A. Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, expenditures made by the state for the items identified below (which are not otherwise included as expenditures) under Section 1903 shall, for the period of this extension, be regarded as expenditures under the State's Title XIX Plan.

1. The subsidy, reimbursement, or voucher, provided to enrollees for their share of medical insurance costs for employer-based and private plans
2. Expenditures for costs incurred as a result of the automatic re-enrollment of enrollees who have regained eligibility within six months, in the last plan of enrollment, and which would not otherwise be eligible for automatic re-enrollment under section 1903(m)(2)(H) of the Act.
3. Expenditures for payments to entities that do not meet federal HMO or state licensure requirements, pursuant to section 1903(m)(1)(A) and (2)(A)(i) of the Act. Such entities consist primarily of PSNs. Such PSNs will not be risk-bearing entities until demonstration year three, but expenditure authority is necessary in the event that the state has not completed promulgating the licensure requirements for PSNs at such time as they become risk-bearing entities.
4. Expenditures made by Florida for costs related to providing health care services to uninsured individuals, subject to the restrictions placed on the Low-Income Pool, as defined in the Special Terms and Conditions.

XI. Budget Neutrality

The Agency projects that budget neutrality will be achieved by reducing the rate of increase in utilization and payment rates for Medicaid services subject to the demonstration, while also making available certain additional benefits as described within the waiver. The savings realized by reducing the rate of increase in Medicaid expenditures for the Medicaid eligibles within the demonstration will be available to increase access to healthcare services for low income and uninsured individuals through a LIP.

Using the provided budget neutrality template, a cost effectiveness analysis of the proposed demonstration program has been completed.

Budget neutrality has been prepared assuming statewide implementation of the waiver.

A. Medicaid Eligibility Groups (MEGs)

The following MEGs are defined as covered populations within the demonstration. All MEGs have been defined as mandatory populations. Please see Table 2 that lists the MEGs and Florida Medicaid Management Information System (FMMIS) codes that have been identified for these categories.

MEG 1 – Supplemental Security Income (SSI) Related. Includes all non-Medicare eligible individuals that are aged or disabled, or have characteristics similar to this population. This group includes:

- Persons receiving SSI cash assistance whose eligibility is determined by the Social Security Administration. Such individuals have an income limit of approximately 75% of the federal poverty level (FPL) and an asset limit of $2,000.
- Persons eligible for the Institutional Care Program (ICP). Includes non-Medicare individuals that qualify for Medicaid benefits with an income level up to 300% of federal poverty level (FPL) and have been determined to need a level of care associated with institutional care. Such care may be provided through a nursing home, hospice, or home and community based service. The asset limit for this category is $2,000 per individual or $3,000 per couple.
- Persons eligible for Developmentally Disabled Waiver (DD) services. Includes non-Medicare individuals that qualify for Medicaid based upon ICP requirements, but have level of care requirements qualifying them for intermediate care for the developmentally disabled. The income limit is up to 300% of FPL, and the asset limit is $2,000 per individual or $3,000 per couple. Please note this waiver does not include any DD-waiver services. Expenditures included in the Medicaid Reform Waiver for DD related individuals are for state plan services and new flexible benefits only.

MEG 2 – Children and Families. Includes all non-Medicare recipients subject to the state's Medicaid income and eligibility criteria and the federal criteria found in Section 1931 of the Social Security Act, and those with similar characteristics.

This group also includes recipients receiving services from the Florida Department of Health's Children's Medical Services. These children are defined by s. 391.021, F.S., and are subject to Medicaid eligibility criteria. They are children younger than 21 years of age who have chronic physical, developmental, behavioral, or emotional conditions and who also require health care and related services of a type or amount beyond that which is generally required by children.

Hospital Inpatient Upper Payment Limit Program expenditures paid through supplemental payments to hospitals are a separate category.

Please reference Table 2 for details regarding excluded individuals.

B. Historical Costs (Current Law Populations)

Historical expenditures for each of the two MEGs have been summarized beginning with State Fiscal Year (SFY) July 1, 1999, through June 30, 2000, and continuing through SFY July 1, 2003, through June 30, 2004. As of the submission date of this waiver, SFY 2003-04 was the most recent period with completed claims data. See Table 3.

All expenditures are based upon claims with dates of service within the timeframe described and include a completion date of six months following the end of the fiscal period.

MEG expenditures include the following:

- State plan services.
- Pharmacy rebates adjustments.
- 1915(b)(3) services related to disease management and incentive arrangements.
- Expenditures for individuals enrolled in managed care plans with capitated rates as the basis for payment.
- Expenditures for managed care plans that use fee-for-service case management and not capitation as the basis for payment.
- Hospital inpatient expenditures related to Medicaid Shortfall payments but administered through the Hospital Inpatient Upper Payment Limit Program (Hospital UPL). All such payments are included within the historic claims data. Supplemental hospital payments made through the Hospital UPL Program have not been included within the MEGs, but have been identified as a separate category.

- Supplemental physician service payments made under the Medicaid State Plan have been included. Such expenditures were allocated based upon the utilization of physician services by year for the MEGs included in the waiver. Only the allocation of these services in relation to MEG expenditures is included in the historical expenditures.
- Nursing home expenditures distributed through the Nursing Home Upper Payment Limit Program (Nursing Home UPL). Such experiences were allocated based upon the utilization of nursing home services by year for the MEGs included in the waiver. Only the allocations of these services in relation to MEG expenditures are included in the historical expenditures.

Please reference Table 2 for excluded services.

Growth rates for both case months and expenditures have been determined using the methodology recommended by the Centers for Medicare and Medicaid Services (CMS), which is an average growth rate based upon data within the historical period, with the following exceptions: each MEG includes various populations that have been analyzed based upon their individual characteristics, and separate inflation factors have been calculated for each of these populations before being summarized into the MEGs shown. Within MEGs 1 and 2, eligibles that qualified for Statewide Inpatient Psychiatric Program (SIPP) services had a growth rate averaged over a three-year period, as the program began during SFY 2001-02.

C. Without-Waiver Budget Projections

Projected expenditures assume claims with dates of service during the projected periods with a completion date of six months following the end of the fiscal period. See Table 4.

Demonstration trend rates (case months and cost per eligible), except for Section 1931, AIDS and SIPP Waiver eligibles, have been based upon the average growth rate as determined by the five-year historical trends. Each MEG includes various populations that have been analyzed based upon their individual characteristics, and separate trend factors have been applied to each of these populations.

Case months for the demonstration period for AIDS Waiver recipients have been continued at the SFY 2003-04 level; no growth or reduction has been applied. During the five-year historic period, case months have declined. The state does not believe this trend will continue, but will instead plateau at the 2003-04 level. Given the level of general education and awareness, the state also does not anticipate this population to experience significant growth. Case months for AIDS Waiver recipients have been included within MEGs 1 and 2.

All expenditures included in historic expenditures are included in the projected Without-Waiver expenditures.

Section 1931 eligible PMPM expenditures were trended based upon the trend rate determined within the recently approved 1915 (b) Managed Care Trend Waiver. This rate of growth was determined to be more reflective of anticipated growth within this eligibility category due to greater use of managed care by Medicaid children and families. Case months were trended using growth rates based upon historic data.

The cost per eligible for those participating in the AIDS Waiver has also decreased an average of nearly 2 percent per year over the five-year historic period. As with case months, the state does not believe this downward trend will continue. Although it is understandable that new drug regimens and treatment protocols have reduced the average cost per recipient within recent history, it is expected that such expenditures should remain relatively constant into the future. Therefore, the cost per eligible for the demonstration periods have been trended at 5.16 percent each year, which is the same as the increase in SFY 2003-04 for the SSI component of the AIDS Waiver eligibility group. The SSI portion of AIDS waiver participants represents 97 percent of the SFY 2003-04 case months. Expenditures for AIDS Waiver recipients have been included within MEGs 1 and 2 based upon which MEG the qualifying case month was classified.

SIPP Waiver trends presented similar challenges, as the program was initiated during SFY 2001-02. Due to surges in growth as this program began operations, historic trends for the three-year period exceeded 50 percent per year, which is not expected to continue. Given the limited resources available for this program, the state projected case months to continue at the SFY 2003-04 level; no growth or reduction has been applied.

Cost per eligible has been trended forward based upon the three-year average calculated using historical experience. SSI-related SIPP expenditures have grown at an average annual PMPM rate of 1.18 percent over the three-year period, and children and family-related SIPP expenditures grew at an annual PMPM rate of 3.57 percent.

The months of aging have been determined as the number of months between the midpoint of the last historic period (SFY 2003-04) and the midpoint of D1 (April 1, 2006 – March 31, 2007), calculated as follows:

		Months to December or D1
SFY 2003-04 Midpoint	1/04	--
Intervening period	1/04-12/05	24
Intervening period	1/05-9/06	9
D1 Midpoint	9/06	--
		33

D. With-Waiver Budget Projections

Projected expenditures assume claims with dates of service during the projected periods with a completion date of 6 months following the end of the fiscal period. See Table 5.

Case months are not expected to be affected by this waiver as eligibility criteria are unchanged. All case-month projections are the same as Without-Waiver case months. The state also anticipate the rate of growth in the historical five-year period to be consistent with the next five-years.

Costs per eligible have been inflated to the beginning of D1 using historical trends except as noted above, using a midpoint to midpoint methodology. Waiver growth trends were then applied to inflate D1 expenditures to the midpoint of D1. All costs in later demonstration periods were inflated at the state With-Waiver trend rates, but based upon the individualized growth rates for the particular populations within each MEG. Future growth rates are a function of trends as described in the Without-Waiver assumptions, as managed care and waiver policies are anticipated to result in a lower level of growth than would have been anticipated. Although per member per month costs are projected to continue to increase under the Medicaid Reform Waiver, the increases are expected to be more controlled and lower than without the waiver.

With-Waiver expenditures are projected on a statewide basis.

The PMPM amounts include expenditures for the new enhanced benefits.

A new section has been added within the With-Waiver template for the LIP. A constant amount of $688,312,448 has been added during each year of the demonstration. This amount was converted into a PMPM amount using the case months for each MEG during D1, and the corresponding PMPM amount was removed from each MEG. This step removes the $688 million from MEGs 1-2, reflecting a constant balance available under the LIP. No explicit growth has been applied to the LIP. The state will use savings generated from MEGs 1-2 during the demonstration period to supplement the base of $688 million.

E. Conclusion

Florida anticipates controlling the rate of growth of future Medicaid expenditures through widespread use of managed care and consumer-directed enhanced benefits. These programmatic changes, applied to the eligibility groups within the waiver, are projected to result in total cost savings during the demonstration period. A portion of these savings is anticipated to be used to provide access to healthcare services to the uninsured through the LIP.

Table 2: Title XIX Eligibles Only
Data Based Upon DOS

For Last 5 Completed Fiscal Years (03/04, 02/03, 01/02, 00/01, 99/00)
Eligibles in the stated Eligibility Categories are subject to be included in the waiver unless the eligible is enrolled in an excluded program. Expenditures for excluded services are excluded for included eligibles.

MEG	Eligibility Group	Eligibility Category	Description
MEG # 1	SSI-Related	MS	SSI Medicaid (Eligibility for Medicaid & usually SSI cash assistance determined by SSA Emergency MICs and retroactive Medicaid coverage on FLORIDA Medicaid)
		MT A	Protected Medicaid for Widows I & kids (disab. defin.change)
		MT C	Regular protected Medicaid (COLA)
		MT D	Protected Medicaid for Disabled Adult Children
		MT S	Protected Medicaid Due to SSI Disability Definition Change
		MT W	Protected Medicaid for Widows II
		MX	SSI Children with continuous coverage
		MI A	Institutional Care Medicaid Supplemental to LIF Medicaid
		MI I	Stand Alone Institutional Care Medicaid
		MI P	Institutional Care Medicaid Supplemental to Protected Medicaid
		MI S	Institutional Care Medicaid Supplemental to SSI Medicaid (MS)
		MI T	Institutional Care Medicaid Failed Due to Transfer of Assets
		MI M	Institutional Care Medicaid Supplemental to MEDS-AD (MMS)
			Recipients enrolled in the DD Waiver (Medical Services Only)
MEG # 2	Children & Families	MA I	Low Income Families (LIF) Medicaid (Incapacitated Parent)
		MA R	Low Income Families (LIF) Medicaid (Deprived Child)
		MA U	Low Income Families (LIF) Medicaid (Unemployed Parent)
		ME C	Extended Medicaid Due to Child Support
		ME I	Transitional Medicaid Due to Caretaker Earned Income
		ME T	Transitional Medicaid Due to Loss of $30 or 1/3 Disregard
		MM C	MEDS for Children Born after 9/30/83
		MM I	MEDS for Infants Under One
		MN	Presumptively Eligible Newborn Medicaid (PEN)
		MO A	"AFDC" Failed Due to Alien Status Medicaid
		MO D	"AFDC" Failed Due to Deemed Income Medicaid
		MO P	"AFDC" Failed Due to Project Independence Sanctions Medicaid
		MO S	"AFDC" Failed Due to Sibling Income Medicaid
		MO T	"AFDC" Failed Due to Transfer of Assets Medicaid
		MO U	LIF Medicaid for Pregnant Women Below TANF (8 months- 9th Month in MA R)
		MO Y	LIF Medicaid for Age 18-21 Deprived Children
		MP C	PMA for Children Under 21 in an Intact Family
		MP N	PMA for Children Born After 9/30/83 Living with Non-relatives
		MP U	PMA for Unemployed Parents with Children Under 18
			Recipients Enrolled in the CMS program

Included Eligibles*	Excluded Eligibles*
MEDIPASS Eligibles	Refugee Eligibles
FFS Eligibles	Dual Eligibles
HMO	Medically Needy
Pilots	PW above TANF Eligible (>27% FPL, SOBRA)
PSN	ICF/DD Eligibles
SIPP Waiver enrollees**	Unborn Children
AIDS Waiver enrollees**	State Mental Facilities (Over Age 65)
ICP Eligibles (Institutional Level of Care up to 300% SSI)	Family Planning Waiver Eligibles
DD Eligibles	Women w/ breast or cervical cancer
	MediKids
Included Services*	**Excluded Services***
Dental	AIDS Waiver (Waiver Services)
Home Safe Net (Medical Services)	DD Waiver (Waiver Services)
Mental Health	Home Safe Net (Behavioral Services)
Transportation	BHOS (Services Only)
Disease Management	Family & Supported Living (W.S.)
MEDIPASS	Katie Beckett Model Waiver Services
MEDIPASS $3 FEE	Brain & Spinal Cord Waiver Services
Nursing Home	School Based Admin Claiming
Hospice	Healthy Start Waiver Services
Aged & Disabled Waiver Services	
Channeling Waiver Services	
Assisted Living Waiver Services	
NH Diversion Waiver Services	
Adult Day Care Waiver Services	
SIPP Waiver Services**	
AIDS Waiver Services**	

*Eligibles are subject to the reform waiver ONLY if eligible for Medicaid Under the specified Eligibility Categories provided in the third column. If eligible is subject to reform by meeting the Eligibility Category requirement, they will be reviewed for included Eligibility and/or Services, then they will be reviewed for Excluded Eligibility and/or services.

**AIDS Waiver and SIPP Waiver eligibles included in SSI and Children & Families based upon economic qualifying criteria.

Table 3: Historic Data: Base Year (BY) and 4 Prior Years for Mandatory Populations

States Would Enter Information In The Shaded Cells. The Rest Of The Sheet Will Be Calculated.
Specify Time Period And Eligibility Group Served:

	SFY 99-00	SFY 00-01	SFY 01-02	SFY 02-03	SFY 03-04	5-Years
Total Expenditures						
Meg 1 - SSI Related	$1,440,343,778	$1,617,655,282	$ 1,754,422,314	$2,047,157,566	$2,203,085,933	$ 9,062,664,872
Eligible Member Months	2,628,839	2,714,382	2,809,223	2,890,214	2,925,038	
Cost Per Eligible	547.90	$ 595.96	$624.52	$ 708.31	753.18	
Trend Rates			**Annual Change**			**5-Year Average**
Total Expenditure		12.31%	8.45%	16.69%	7.62%	11.21%
Eligible Member Months		3.25%	3.49%	2.88%	1.20%	2.71%
Cost Per Eligible		8.77%	4.79%	13.42%	6.34%	8.28%
Total Expenditures						
Meg 2 - Child & Fam	$1,514,685,517	$1,773,620,212	$ 1,926,206,807	$2,204,501,439	$2,473,745,468	$9,892,759,442
Eligible Member Months	10,811,633	12,453,014	13,748,522	14,908,204	15,621,916	
Cost Per Eligible	140.10	142.42	140.10	147.87	158.35	
Trend Rates			**Annual Change**			**5-Year Average**
Total Expenditure		17.09%	8.60%	14.45%	12.21%	13.05%
Eligible Member Months		15.18%	10.40%	8.43%	4.79%	9.64%
Cost Per Eligible		1.66%	-1.63%	5.55%	7.09%	3.11%
Total Expenditures						
Hospital Inpatient Supplemental Payments	$0	$ 144,349,164	$ 492,489,289	$ 459,822,314	$ 567,495,029	$1,664,155,796
Eligible Member Months	0	0	0	0	0	
Cost Per Eligible `	NA	NA	NA	NA	NA	
Trend Rates			**Annual Change**			**4-Year Average**
Total Expenditure		NA	241.18%	-6.63%	23.42%	57.83%
Eligible Member Months		NA	NA	NA	NA	NA
Cost Per Eligible		NA	NA	NA	NA	NA

Table 4: Demonstration without Waiver (WOW) Budget Projection

MANDATORY POPULATIONS

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01 4/1/06-3/31/07	DY 02 4/1/07-3/31/08	DY 03 4/1/08-3/31/09	DY 04 4/1/09-3/31/10	DY 05 4/1/10-3/31/11	TOTAL WOW
MEG 1 - SSI RELATED								
Eligible Member Months	2.76%	33	3,150,897	3,237,968	3,327,845	3,420,646	3,516,494	
Total Cost Per Eligible	8.73%	33	$944	$1,027	$1,118	$1,217	$ 1,327	
Total Expenditure			$2,975,596,229	$3,324,900,975	$3,718,902,382	$4,163,989,499	$4,667,586,111	$18,850,975,196
MEG 2 - CHILD & FAM								
Eligible Member Months	9.80%	33	20,131,552	22,079,209	24,216,776	26,562,827	29,137,756	
Total Cost Per Eligible	7.96%	33	$ 194	$ 209	$ 226	$245	$ 265	
Total Expenditure			$3,902,199,885	$4,620,202,804	$5,478,366,374	$ 6,504,681,492	$7,732,775,724	$28,238,226,279
HOSPITAL INPATIENT SUPPLEMENTAL PAYMENTS								
Eligible Member Months	0.00%	33	0	0	0	0	0	0
Total Cost Per Eligible	20.33%	33	$0	$0	$0	$0	$0	$0
Total Expenditure			$ 787,360,609	$ 947,431,021	$1,140,043,748	$1,371,814,642	$ 1,650,704,558	$5,897,354,578

Table 5: Demonstration with Waiver (WW) Budget Projection

MANDATORY POPULATIONS

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY) DY 01 4/1/06-3/31/07	DY 02 4/1/07-3/31/08	DY 03 4/1/08-3/31/09	DY 04 4/1/09-3/31/10	DY 05 4/1/10-3/31/11	TOTAL WW
MEG 1 - SSI RELATED								
Eligible Member Months	2.76%	33	3,150,897	3,237,968	3,327,845	3,420,646	3,516,494	
Total Cost Per Eligible	7.03%	26	$936	$1,002	$1,073	$1,150	$1,233	
Total Expenditure			$2,948,516,733	$3,242,956,545	$3,569,663,911	$3,932,622,123	$4,336,375,468	$18,030,134,780
MEG 2 - CHILD & FAM								
Eligible Member Months	9.67%	33	20,131,552	22,079,209	24,216,776	26,562,827	29,137,756	
Total Cost Per Eligible	6.23%	26	$192	$204	$217	$231	$246	
Total Expenditure			$3,866,100,441	$4,504,092,763	$5,253,744,917	$6,135,051,187	$7,171,616,475	$26,930,605,782
LOW INCOME SUBSIDY POOL								
Eligible Member Months	0.00%		0	0	0	0	0	
Total Cost Per Eligible	0.00%		$0	$0	$0	$0	$0	
Total Expenditure			$688,312,448	$688,312,448	$688,312,448	$688,312,448	$688,312,448	$3,441,562,240

NOTE: Florida projects spending from the Low Income Pool above the $688,312,448 to be made from savings generated by the waiver, subject to the Special Terms and Conditions finalized by the Centers for Medicare and Medicaid Services.

Appendix I:
Current Environment

Florida implemented Medicaid managed care in 1982, when the Palm Beach County Public Health Unit began operating Florida's first Medicaid managed care plan. In 1984, Florida was selected as one of five states to receive a grant from what is now the Centers for Medicare and Medicaid Services, formerly named Health Care Financing Administration (HCFA), to implement a demonstration program. Between 1984 and 1990 eligible Medicaid recipients were provided the opportunity to enroll in Medicaid health maintenance organizations (HMO). Since Medicaid HMOs were not available statewide, many areas of the state were initially left uncovered. In response, Florida developed a primary care case management (PCCM) program known as MediPass as an alternative strategy to expand managed care throughout the state and to provide Medicaid recipients with another managed care option.

Since implementation of MediPass in 1990, Medicaid managed care has evolved into a variety of programs including managed care organizations (MCO), primary care case management programs, prepaid inpatient health plans (PIHP), and prepaid ambulatory health plans (PAHP). In general, the state has created a menu of options from which an individual may choose. The state has also created special programs specifically for individuals enrolled in MediPass (PCCM). These programs include the prepaid mental health plans and all PAHPs with the exception of Minority Physician Networks and Pediatric Emergency Room Diversion Program, which are other managed care options.

Delivery System	Program Name
MCO	Health Maintenance Organizations
	Frail / Elderly Program
	Exclusive Provider Organization
PCCM	MediPass
	Children's Medical Services Network
PIHP	Provider Service Network
	Prepaid Mental Health Plan
PAHP	Prepaid Dental Health Plan
	Minority Physicians Networks
	Pediatric Emergency Room Diversion Program

Of the 2.2 million individuals eligible for Medicaid, 1.5 million are enrolled in one of the managed care programs. Of this number, over 700,000 individuals are enrolled in primary care case management (PCCM) programs that are paid on a fee-for-service basis. In an effort to better manage their care, individuals enrolled in MediPass may also be enrolled in other managed care programs. For example, an individual in

MediPass may also be enrolled in the prepaid mental health program and the prepaid dental program. This has created a fragmented system of carve outs. HMOs are currently the only entities that provide coverage for a comprehensive set of services; however, they are operational in only 33 of 67 counties. This results in limited competition in many parts of the state. Additional detail regarding the delivery systems identified in the chart above is provided below. Current enrollment figures for each program are provided in the tables provided on page 77.

Managed Care Organizations (MCOs)

Florida operates two types of MCOs: health maintenance organizations and exclusive provider organizations. All MCOs including all other types of managed care plans are required to ensure that all covered services are available and accessible to enrollees. Enrollees receive information about choice of health care providers; a description of services available including limitations and general restrictions on provider access, exclusions and out-of-network use of providers; and a description of enrollee rights and responsibilities.

Medicaid Health Maintenance Organization (HMO)
Medicaid HMOs are fully capitated entities licensed under Chapter 641, Florida Statutes, at risk for inpatient hospitalization and any other covered services. Currently, Florida Medicaid contracts with eleven Medicaid HMOs with over 750,000 enrollees for the provision of comprehensive health care services. The state identifies a set of mandatory and optional service that HMOs must cover. HMOs have the option to provide dental, transportation, nursing facility and home and community-based services. An HMOs service package cannot be more restrictive than those provided under Medicaid fee-for-service. HMOs may require that services be prior authorized, except for emergency, family planning, chiropractic, podiatric, and some dermatology services. HMO's may also provide services under the contract that Medicaid does not cover, such as over-the-counter drugs.

Medicaid Exclusive Provider Organization (EPO)
Medicaid EPOs are fully capitated entities licensed under Chapter 627, Florida Statutes, at risk for inpatient hospitalization and any other covered services. An EPO is an organization of health care providers, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits under a health insurance policy issued under Section 627.6472, Florida Statutes. An EPO is similar to an HMO regarding the type of covered services, but is designed to fit the specific needs of many underserved rural counties and excludes Medicare dual eligibles. The state anticipates entering into its first contract with an EPO in 2005.

Primary Care Case Management (PCCM)

Florida operates two types of PCCMs: the MediPass Program and the Children's Medical Services (CMS) Network. Florida's PCCM programs are systems of care under

which primary care case managers contract to case manage the care of enrollees on a non-risk basis with a $3.00 per member per month case management fee. All services are paid for on a fee-for-service basis. PCCMs provide enrollees primary care services, 24-hour access to care and referral and authorization for specialty services and hospital care.

Medicaid Physician Access System (MediPass)
MediPass is offered statewide and was established as an alternative managed care option to HMOs. MediPass was intended to provide eligible beneficiaries improved access to health care, improve continuity of services, strengthen the patient/physician relationship, promote the educational and preventative aspects of health care, reduce unnecessary service utilization, and reduce Medicaid expenditures. MediPass provides primary care services, 24-hour access to care, and referral and authorization for specialty services.

Children's Medical Services (CMS) Network
The CMS Network provides coordinated primary and tertiary care to Medicaid-eligible children with special health care needs who meet CMS eligibility criteria on a statewide basis. The CMS Network provides eligible children with a coordinated system of health care that links community-based health care with multidisciplinary, regional and tertiary care. CMS Network-eligible children are assigned to a CMS Network primary care provider and receive ongoing support from CMS Network care coordinators within the local CMS Network field offices.

Prepaid Inpatient Health Plan (PIHP)

Florida operates two types of PIHP: the PSNs and the Prepaid Mental Health Plans (PMHPs).

Provider Service Networks (PSNs)
In 1997, the Agency was authorized to establish Medicaid PSNs as a demonstration project to develop a successful managed care partnership between Florida Medicaid and various historical high-volume providers of care to Florida's Medicaid enrollees. After a competitive bidding process, a PSN was selected and became operational in 2000. Florida's PSN is an integrated health care delivery system owned and operated by Florida hospitals and physician groups. The PSN is a non-risk-bearing entity and is paid on a fee-for-service basis. The PSN provides all Medicaid-covered services to eligible beneficiaries including inpatient hospitalization.

Prepaid Mental Health Plans (PMHPs)
In 1996, the Agency began contracting with PMHPs, which are limited risk-bearing entities to provide mental health services in the most cost-effective manner to eligible beneficiaries in selected areas of the state. PMHPs are currently operated in Medicaid Area Six and Area One with recent legislation mandating statewide expansion of the plans. The PMHPs are selected through competitive procurement to provide, on a

limited capitated basis, the following mental health services: community mental health, mental health targeted case management, inpatient psychiatric hospitalization (emergency and non-emergency), and outpatient psychiatric hospitalization (mental health and physician services). The PMHP entities assume all the risk for the limited set of services they provide. PMHP enrollees receive their remaining health care services through MediPass.

Prepaid Ambulatory Health Plan (PAHP)

Florida operates three PAHPs: Prepaid Dental Health Plan (PDHP), the Minority Physician Networks (MPNs), and the Pediatric Emergency Room (ER) Diversion Program in selected areas of the state.

Prepaid Dental Health Plan (PDHP)
In July 2004, the Agency began contracting with a single PDHP to provide dental services on a limited capitated basis to Medicaid-eligible children under the age of 21 in Miami-Dade County. The PDHP provides all dental services.

Minority Physician Networks (MPNs)
In 2003, the Agency established agreements with two physician-owned MPNs in which the majority of physicians are members of racial and ethnic minority groups. The MPNs provide enhanced primary care case management services. In addition, the MPNs support the primary care case managers by providing administrative and utilization management services as a means of containing cost and enhancing the quality of care. The MPN primary care providers are paid $3.00 per member per month for case management services and paid on a fee-for-service basis for all services provided. In addition, they are eligible to receive a portion of shared savings.

Pediatric Emergency Room (ER) Diversion Program
In 2002, the Agency established agreements with Pediatric ER Diversion Programs as an alternative managed care option in Medicaid Area 10, Broward County. The Pediatric ER Diversion Programs were designed to manage patient care to ensure adequate access to primary care, reduce inappropriate utilization of emergency services, control program costs, and improve health outcomes. The ER Diversion primary care providers are paid $3.00 per member per month for case management services and paid on a fee-for-service basis for all services provided. In addition, they are eligible to receive a portion of shared savings.

June 2005 Enrollment by SSI and TANF

Program	Number of Enrolled	Percent SSI	Percentage TANF
HMO	781,521	14.6%	85.4%
MediPass	571,449	20.7%	79.3%
Children's Medical Service Networks	25,889	54%	46%
Provider Service Networks (PSNs)	18,087	29.1%	70.9%
Minority Physician Networks (MPNs)	118,040	20.0%	80.0%
Pediatric Emergency Room (ER) Diversion	16,173	4.3%	95.7%
Total PCCM	747,579	18.1%	81.9%

June 2005 HMO Enrollment Snapshot*

Plan Name	Counties Served	#TANF Enrolled	% TANF Enrolled	#SSI Enrolled	% SSI Enrolled	# Total Enrolled
AMERIGROUP	13	135,843	84%	25,553	16%	161,396
BUENA VISTA	10	24,745	88%	3,242	12%	27,897
CITRUS HEALTH CARE	4	8,258	89%	1,036	11%	9,294
HEALTHEASE	30	190,862	87%	29,133	13%	219,995
HEALTHY PALM BEACHES	1	5,241	100%	0	0%	5,241
HUMANA FAMILY	3	44,820	83%	9,478	17%	54,298
JMH HEALTH PLAN	1	11,921	83%	2,369	17%	14,290
PREFERRED MEDICAL PLAN	2	14,186	87%	2,030	13%	16,216
STAYWELL	15	162,846	85%	28,734	15%	191,580
UNITED HEALTHCARE PLAN	13	54,917	86%	9,098	14%	64,015
VISTA HealthPlan of S. FL	1	13,032	76%	4,177	24%	17,209
TOTAL	33*	666,671	85%	114,850	15%	781,521

*Unduplicated count

Florida Health Maintenance Organizations – June 2005

CNTY #	COUNTY	DIST	AETNA U.S. HEALTHCARE	AMERICA'S HEALTH CHOICE MEDICAL PLANS, INC.	AMERIGROUP FLORIDA, INC.	AV-MED, INC.	CAPITAL GROUP HEALTH SERVICES OF FLORIDA	CAREPLUS HEALTH PLANS, INC.	CIGNA HEALTHCARE OF FLORIDA, INC.	CITRUS HEALTH CARE, INC.	DOCTORCARE, INC.	FLORIDA HEALTH CARE PLAN, INC.
01	ALACHUA	03	C			C			C			
02	BAKER	04	C			C						
03	BAY	02										
04	BRADFORD	03				C			C			
05	BREVARD	07	C	MA	M				C			
06	BROWARD	10	C	MA	HK M	C MA		MA	C	MA		
07	CALHOUN	02										
08	CHARLOTTE	08	C					MA	C			
09	CITRUS	03				C						
10	CLAY	04	C			C			C			
11	COLLIER	08						MA				
12	COLUMBIA	03				C			C			
13	DADE	11	C		HK M	C MA		MA	C	MA	MA	
14	DESOTO	08						MA				
15	DIXIE	03				C						
16	DUVAL	04	C			C			C			
17	ESCAMBIA	01										
18	FLAGLER	04							C			C HK MA
19	FRANKLIN	02										
20	GADSDEN	02					C MA					
21	GILCHRIST	03				C						
22	GLADES	08										
23	GULF	02										
24	HAMILTON	03				C						
25	HARDEE	06						MA				

CNTY #	COUNTY	DIST	AETNA U.S. HEALTHCARE	AMERICA'S HEALTH CHOICE MEDICAL PLANS, INC.	AMERIGROUP FLORIDA, INC.	AV-MED, INC.	CAPITAL GROUP HEALTH SERVICES OF FLORIDA	CAREPLUS HEALTH PLANS, INC.	CIGNA HEALTHCARE OF FLORIDA, INC.	CITRUS HEALTH CARE, INC.	DOCTORCARE, INC.	FLORIDA HEALTH CARE PLAN, INC.
26	HENDRY	08										
27	HERNANDO	03	C			C			C	M		
28	HIGHLANDS	06						MA				
29	HILLSBOROUGH	06	C		HK M	C		MA	C	C M MA		
30	HOLMES	02										
31	INDIAN RIVER	09		MA					C			
32	JACKSON	02										
33	JEFFERSON	02					C MA					
34	LAFAYETTE	03										
35	LAKE	03	C						C	MA		
36	LEE	08	C		M	C		MA	C			
37	LEON	02					C MA					
38	LEVY	03				C						
39	LIBERTY	02										
40	MADISON	02										
41	MANATEE	06	C		M			MA	C			
42	MARION	03	C			C			C			
43	MARTIN	09	C	MA					C			
44	MONROE	11										
45	NASSAU	04	C			C			C			
46	OKALOOSA	01										
47	OKEECHOBEE	09		MA					C			
48	ORANGE	07	C		HK M	C		MA	C	C MA		
49	OSCEOLA	07	C		M	C		MA	C	C MA		
50	PALM BEACH	09	C	MA	HK M	C		MA	C	M		
51	PASCO	05	C		HK M	C		MA	C	C MA		
52	PINELLAS	05	C		HK M	C		MA	C	C M MA		
53	POLK	06	C		HK M	C		MA	C	C M		

CNTY #	COUNTY	DIST	AETNA U.S. HEALTHCARE	AMERICA'S HEALTH CHOICE MEDICAL PLANS, INC.	AMERIGROUP FLORIDA, INC.	AV-MED, INC.	CAPITAL GROUP HEALTH SERVICES OF FLORIDA	CAREPLUS HEALTH PLANS, INC.	CIGNA HEALTHCARE OF FLORIDA, INC.	CITRUS HEALTH CARE, INC.	DOCTORCARE, INC.	FLORIDA HEALTH CARE PLAN, INC.
54	PUTNAM	03							C			
57	SANTA ROSA	01										
58	SARASOTA	08	C		M	C		MA	C			
59	SEMINOLE	07	C		M	C		MA	C	MA		C HK MA
55	ST. JOHNS	04				C			C			
56	ST. LUCIE	09		MA					C			
60	SUMTER	03							C			
61	SUWANNEE	03				C						
62	TAYLOR	02										
63	UNION	03				C			C			
64	VOLUSIA	04	C					MA	C	MA		C HK MA
65	WAKULLA	02					C MA					
66	WALTON	01										
67	WASHINGTON	02										
	COUNTY TOTALS		25	7	14	29	4	19	34	13	1	3

C=Commercial
HK=Healthy Kids
M=Medicaid
MA=Medicare

CNTY #	COUNTY	DIST	FREEDOM HEALTH, INC.	GREAT-WEST HEALTHCARE OF FLORIDA, INC.	HEALTHEASE OF FLORIDA, INC.	HEALTH FIRST HEALTH PLANS, INC.	HEALTH OPTIONS, INC.	HEALTH SUN HEALTH PLANS, INC	HEALTHY PALM BEACHES, INC.	HUMANA MEDICAL PLAN, INC.	LEON MEDICAL CENTERS HEALTH PLANS, INC.	MEDICA HEALTHCARE PLANS, INC.
01	ALACHUA	03					C MA			C MA		
02	BAKER	04			M		C MA			C MA		
03	BAY	02										
04	BRADFORD	03					C MA			C MA		
05	BREVARD	07			M	C MA	C MA			C MA		
06	BROWARD	10		C	M		C MA			C MA M		MA
07	CALHOUN	02			M							
08	CHARLOTTE	08					C MA					
09	CITRUS	03			HK M		C MA			C MA		
10	CLAY	04			M		C HK MA			C MA		
11	COLLIER	08								C MA		
12	COLUMBIA	03					C MA			C MA		
13	DADE	11		C	M		C MA	MA		C MA M	MA	MA
14	DESOTO	08					C MA					
15	DIXIE	03					C MA			C MA		
16	DUVAL	04			HK M		C MA			C MA		
17	ESCAMBIA	01			HK M		C HK MA					
18	FLAGLER	04					C MA			C MA		
19	FRANKLIN	02			M							
20	GADSDEN	02			M							
21	GILCHRIST	03					C MA			C MA		
22	GLADES	08								C MA		
23	GULF	02										
24	HAMILTON	03										
25	HARDEE	06								C MA		
26	HENDRY	08					C MA			C MA		

CNTY #	COUNTY	DIST	FREEDOM HEALTH, INC.	GREAT-WEST HEALTHCARE OF FLORIDA, INC.	HEALTHEASE OF FLORIDA, INC.	HEALTH FIRST HEALTH PLANS, INC.	HEALTH OPTIONS, INC.	HEALTH SUN HEALTH PLANS, INC	HEALTHY PALM BEACHES, INC.	HUMANA MEDICAL PLAN, INC.	LEON MEDICAL CENTERS HEALTH PLANS, INC.	MEDICA HEALTHCARE PLANS, INC.
27	HERNANDO	03					C MA			C MA		
28	HIGHLANDS	06			HK M		C MA			C MA		
29	HILLSBOROUGH	06		C	M		C MA			C MA		
30	HOLMES	02										
31	INDIAN RIVER	09				C MA				C MA		
32	JACKSON	02										
33	JEFFERSON	02			HK M					C MA		
34	LAFAYETTE	03										
35	LAKE	03			HK M		C MA			C MA		
36	LEE	08		C			C MA			C MA		
37	LEON	02			M							
38	LEVY	03					C MA			C MA		
39	LIBERTY	02			M							
40	MADISON	02			HK M							
41	MANATEE	06			M		C MA			C MA		
42	MARION	03	MA		M		C MA			C MA		
43	MARTIN	09			HK M		C MA			C MA		
44	MONROE	11								C MA		
45	NASSAU	04					C MA			C MA		
46	OKALOOSA	01					C HK MA					
47	OKEECHOBEE	09					C MA			C MA		
48	ORANGE	07		C	M		C MA			C MA		
49	OSCEOLA	07		C	M		C MA			C MA		
50	PALM BEACH	09		C	M		C MA		M	C MA M		
51	PASCO	05		C	M		C MA			C MA		
52	PINELLAS	05		C	M		C MA			C MA		
53	POLK	06		C	M		C MA			C MA		
54	PUTNAM	03			HK M					C MA		

CNTY #	COUNTY	DIST	FREEDOM HEALTH, INC.	GREAT-WEST HEALTHCARE OF FLORIDA, INC.	HEALTHEASE OF FLORIDA, INC.	HEALTH FIRST HEALTH PLANS, INC.	HEALTH OPTIONS, INC.	HEALTH SUN HEALTH PLANS, INC	HEALTHY PALM BEACHES, INC.	HUMANA MEDICAL PLAN, INC.	LEON MEDICAL CENTERS HEALTH PLANS, INC.	MEDICA HEALTHCARE PLANS, INC.
57	SANTA ROSA	01			M		C HK MA					
58	SARASOTA	08			M		C MA			C MA		
59	SEMINOLE	07		C	M		C MA			C MA		
55	ST. JOHNS	04					C MA			C MA		
56	ST. LUCIE	09					C MA			C MA		
60	SUMTER	03	MA				C MA					
61	SUWANNEE	03					C MA					
62	TAYLOR	02										
63	UNION	03								C MA		
64	VOLUSIA	04			M		C MA			C MA		
65	WAKULLA	02			HK M							
66	WALTON	01					C MA					
67	WASHINGTON	02										
	COUNTY TOTALS		2	11	33	2	43	1	1	44	1	2

C=Commercial
HK=Healthy Kids
M=Medicaid
MA=Medicare

CNTY #	COUNTY	DIST	METCARE HEALTH PLANS, INC.	NEIGHBORHOOD HEALTH PARTNERSHIP, INC.	PREFERRED CARE PARTNERS, INC.	PREFERRED MEDICAL PLAN, INC.	QUALITY HEALTH PLANS, INC.	SUMMIT HEALTH PLAN, INC.	SUNCOAST PHYSICIANS HEALTH PLAN, INC.	THE PUBLIC HEALTH TRUST OF DADE COUNTY	TOTAL HEALTH CHOICE, INC.	UNITED HEALTHCARE OF FLORIDA, INC.
01	ALACHUA	03										C MA
02	BAKER	04										
03	BAY	02										
04	BRADFORD	03										C MA
05	BREVARD	07										C M MA
06	BROWARD	10		C MA	MA	C M		MA	MA	C M	C	C HK M MA
07	CALHOUN	02										
08	CHARLOTTE	08	MA									C MA
09	CITRUS	03										C MA
10	CLAY	04										C MA
11	COLLIER	08										C MA
12	COLUMBIA	03										C MA
13	DADE	11		C MA	MA	C M		MA	MA	C M	C	C HK M MA
14	DESOTO	08										C MA
15	DIXIE	03										
16	DUVAL	04					MA					C HK MA
17	ESCAMBIA	01										C MA
18	FLAGLER	04										C MA
19	FRANKLIN	02										
20	GADSDEN	02										
21	GILCHRIST	03										
22	GLADES	08										
23	GULF	02										
24	HAMILTON	03										
25	HARDEE	06										
26	HENDRY	08										
27	HERNANDO	03					MA					C MA

CNTY #	COUNTY	DIST	METCARE HEALTH PLANS, INC.	NEIGHBORHOOD HEALTH PARTNERSHIP, INC.	PREFERRED CARE PARTNERS, INC.	PREFERRED MEDICAL PLAN, INC.	QUALITY HEALTH PLANS, INC.	SUMMIT HEALTH PLAN, INC.	SUNCOAST PHYSICIANS HEALTH PLAN, INC.	THE PUBLIC HEALTH TRUST OF DADE COUNTY	TOTAL HEALTH CHOICE, INC.	UNITED HEALTHCARE OF FLORIDA, INC.
28	HIGHLANDS	06										C M MA
29	HILLSBOROUGH	06					MA					C M MA
30	HOLMES	02										
31	INDIAN RIVER	09										C MA
32	JACKSON	02										
33	JEFFERSON	02										
34	LAFAYETTE	03										
35	LAKE	03					MA					C M MA
36	LEE	08	MA									C MA
37	LEON	02										C MA
38	LEVY	03										
39	LIBERTY	02										
40	MADISON	02										
41	MANATEE	06					MA					C MA
42	MARION	03										C MA
43	MARTIN	09	MA									C MA
44	MONROE	11										
45	NASSAU	04										C MA
46	OKALOOSA	01										C MA
47	OKEECHOBEE	09	MA									C MA
48	ORANGE	07					MA					C M MA
49	OSCEOLA	07					MA					C M MA
50	PALM BEACH	09		C MA				MA	MA		C	C M MA
51	PASCO	05					MA					C M MA
52	PINELLAS	05					MA					C M MA
53	POLK	06					MA					C MA
54	PUTNAM	03										C MA
57	SANTA ROSA	01										C MA

CNTY #	COUNTY	DIST	METCARE HEALTH PLANS, INC.	NEIGHBORHOOD HEALTH PARTNERSHIP, INC.	PREFERRED CARE PARTNERS, INC.	PREFERRED MEDICAL PLAN, INC.	QUALITY HEALTH PLANS, INC.	SUMMIT HEALTH PLAN, INC.	SUNCOAST PHYSICIANS HEALTH PLAN, INC.	THE PUBLIC HEALTH TRUST OF DADE COUNTY	TOTAL HEALTH CHOICE, INC.	UNITED HEALTHCARE OF FLORIDA, INC.
58	SARASOTA	08	MA				MA					C MA
59	SEMINOLE	07					MA					C M MA
55	ST. JOHNS	04										C HK MA
56	ST. LUCIE	09	MA									
60	SUMTER	03					MA					
61	SUWANNEE	03										C MA
62	TAYLOR	02										
63	UNION	03										C MA
64	VOLUSIA	04										C M MA
65	WAKULLA	02										
66	WALTON	01										
67	WASHINGTON	02										
	COUNTY TOTALS		6	3	2	2	13	3	3	2	3	41

C=Commercial
HK=Healthy Kids
M=Medicaid
MA=Medicare

CNTY #	COUNTY	DIST	UNITED HEALTHCARE OF FLORIDA, INC.	UNIVERSAL HEALTH CARE, INC.	VISTA HEALTHPLAN, INC.	VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.	WELL CARE OF FLORIDA, INC.
01	ALACHUA	03	C MA		C HK		
02	BAKER	04					
03	BAY	02					
04	BRADFORD	03	C MA		C MA		
05	BREVARD	07	C M MA				C HK M
06	BROWARD	10	C HK M MA		C HK M MA	C	C HK M
07	CALHOUN	02		C MA	C HK		
08	CHARLOTTE	08	C MA				C HK
09	CITRUS	03	C MA				
10	CLAY	04	C MA				C
11	COLLIER	08	C MA				C HK
12	COLUMBIA	03	C MA		C HK		
13	DADE	11	C HK M MA		C HK M MA	C M MA	C HK M MA
14	DESOTO	08	C MA				C HK
15	DIXIE	03			C HK		
16	DUVAL	04	C HK MA				C
17	ESCAMBIA	01	C MA		C		MA
18	FLAGLER	04	C MA				
19	FRANKLIN	02		C MA	C HK		
20	GADSDEN	02		C MA	C HK M		
21	GILCHRIST	03			C HK		
22	GLADES	08					
23	GULF	02					
24	HAMILTON	03			C HK		
25	HARDEE	06					
26	HENDRY	08			C M		

CNTY #	COUNTY	DIST	UNITED HEALTHCARE OF FLORIDA, INC.	UNIVERSAL HEALTH CARE, INC.	VISTA HEALTHPLAN, INC.	VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.	WELL CARE OF FLORIDA, INC.
27	HERNANDO	03	C MA	C HK MA			C HK M MA
28	HIGHLANDS	06	C M MA				
29	HILLSBOROUGH	06	C M MA	C MA			C HK M MA
30	HOLMES	02					
31	INDIAN RIVER	09	C MA				
32	JACKSON	02					
33	JEFFERSON	02		C MA	C M		
34	LAFAYETTE	03			C HK		
35	LAKE	03	C M MA				C
36	LEE	08	C MA				C HK M
37	LEON	02	C MA	C MA	C HK M		
38	LEVY	03			C HK		
39	LIBERTY	02		C MA	C HK M		
40	MADISON	02		C MA	C M		
41	MANATEE	06	C MA	C HK MA			C HK M
42	MARION	03	C MA		C HK		
43	MARTIN	09	C MA			C	
44	MONROE	11					
45	NASSAU	04	C MA				
46	OKALOOSA	01	C MA				C
47	OKEECHOBEE	09	C MA				
48	ORANGE	07	C M MA				C HK M MA
49	OSCEOLA	07	C M MA				C HK M MA
50	PALM BEACH	09	C M MA	C MA	C HK M MA	C	C HK M MA
51	PASCO	05	C M MA	C MA			M MA
52	PINELLAS	05	C M MA	C MA			C HK M MA
53	POLK	06	C MA	C MA			M
54	PUTNAM	03	C MA				

CNTY #	COUNTY	DIST	UNITED HEALTHCARE OF FLORIDA, INC.	UNIVERSAL HEALTH CARE, INC.	VISTA HEALTHPLAN, INC.	VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.	WELL CARE OF FLORIDA, INC.
57	SANTA ROSA	01	C MA		C		MA
58	SARASOTA	08	C MA	C HK MA			C HK M
59	SEMINOLE	07	C M MA				C HK M MA
55	ST. JOHNS	04	C HK MA				
56	ST. LUCIE	09				C	C
60	SUMTER	03					
61	SUWANNEE	03	C MA		C HK		
62	TAYLOR	02					
63	UNION	03	C MA		C HK		
64	VOLUSIA	04	C M MA				
65	WAKULLA	02		C MA	C M		
66	WALTON	01					
67	WASHINGTON	02					
	COUNTY TOTALS		41	15	25	5	25

C=Commercial
HK=Healthy Kids
M=Medicaid
MA=Medicare

Appendix II:
Phase-In of Implementation

Roll Out Reform Plan in Duval and Broward Counties

The tables below, indicate Reform will start in Broward and Duval Counties and provide an overview of the transition. The model assumes that during the transition period, there will be 131,065 individuals in Broward County and 78,124 in Duval County enrolled in a managed care plan under Reform. These figures are the current managed care enrollment levels as of June 2005 and do not include unassigned individuals. No increase in new eligibles or total enrollment is assumed. Below is a summary of the transition in the first year.

Broward County

As of June 2005, the state contracts with one PSN, two MPNs and one ER diversion program with a total enrollment of 31,881. The state also contracts with seven HMOs with a total enrollment of 74,121. The current managed care plans will have to apply as a reform plan to participate. The Agency assumes that there will be at least two managed care reform plans. If all plans continue as reform plans, there will be at least 11 managed care choices. Individuals in MediPass will be required to select a reform plan at the time of eligibility redetermination. The model assumes that one-twelfth of the current managed care enrollees will transfer to a managed care plan under Reform every month. These enrollees are assumed to choose or be assigned to an HMO or PSN equally. Enrollees in a PSN, MPN, or ER diversion program will also be given the opportunity to change plans at the time of redetermination. However, should the plan participate under Reform, it is assumed that the individual will elect to remain enrolled in the same plan. At the end of the transition period, enrollment in PSN reform plans and managed care reform plans is estimated to increase by 12,531, which represents half of the total MediPass enrollment at implementation.

Broward County	**4/1/2006-6/30/2007**	
	Start	**End**
PSN-MPN-ER Diversion (4)	31,881	-
HMO (7)	74,121	-
MediPass	25,063	-
PSNs Reform	-	47,413
HMOs Reform	-	86,653
Total Enrollment in Reform		**134,065**

Duval County

As of June 2005, the state contracted with one MPN with a total enrollment of 3,826 and one HMO with a total enrollment of 41,418. The Agency assumes that if both plans continue as reform plans, there will be at least two managed care choices. Therefore, individuals in MediPass will be required to select a reform plan at the time of eligibility redetermination. It is assumed that one-twelfth of the current managed care enrollees will transfer to a managed care plan under Reform every month. These enrollees are assumed to choose or be assigned to an HMO or PSN equally. Enrollees in the MPN or HMO will also be given the opportunity to change plans at the time of redetermination. Should a plan participate under Reform, it is assumed that the individual will elect to remain enrolled in the same plan. At the end of the transition period, enrollment in PSN reform plans and managed care reform plans is assumed to increase by 16,440, which represents half of the total MediPass enrollment at implementation.

Duval County	**4/1/2006-6/30/2007**	
	Start	**End**
PSN-MSN	3,826	-
HMO	41,418	-
MediPass	32,880	-
PSN Reform	-	20,266
HMO Reform	-	57,858
Total Enrollment in Reform		**78,124**

Assumptions:

- Enrollment levels as of June 2005 are assumed to remain the same at the time of implementation
- Enrollment choice will be made at redetermination of Medicaid eligibility.
- The total managed care eligible population will go through redetermination within 12 months
- Enrollment choices will be made by 1/12 of the total population each month in each county
- In Broward county there will be 2,088 choosers from MediPass each month, 6,177 choosers from the HMO each month, and 2,656 choosers from the PSN-MSN each month.
- In Duval county there will be 2,740 choosers from MediPass each month, 3,451 choosers from the HMO each month, 319 choosers from the MPN
- The split between the new reform plans will be 50%-50% for MediPass enrollees
- People currently enrolled in a PSN, MPN or HMO are assigned to the reform choice of the current choice (100% of PSN goes to PSN reform, 100% of HMO goes to HMO reform)

Actual experience may deviate from the estimates.

Appendix III:
State Plan Covered Services

Mandatory Services
Advanced Registered Nurse Practitioner Services
County Health Department Services
Dental Services - Children
Dental Services – Children
Child Health Check-Up Services
Emergency Services
Family Planning Services
Federally Qualified Health Centers
Hearing Services*
Home Health Care Services – Private Duty Nurses*
Hospital Services – Inpatient
Hospital Services – Outpatient
Independent Laboratory Services
Licensed Midwife Services
Optometric Services*
Physician Services
Physician Assistant Services
Rural Health Clinic Services
Therapy Services – Occupational*
Therapy Services – Physical*
Therapy Services – Respiratory*
Therapy Services – Speech*
Transportation
Visual Services – Children

**Under age 21*

Optional Services
Advanced Registered Nurse Practitioner Services
Assistive Care Services
Birth Center Services
Chiropractic Services
Community Mental Health Services
County Health Department Services
Dental Services - Children
Durable Medical Equipment and Medical Supplies
Freestanding Dialysis Centers
Home Health Care Service
Podiatry Services
Prescribed Drugs
Targeted Case Management
Visual Services - Adult

Appendix IV:
Benefit Plan Evaluation Prototype

The purpose of this model is to provide an Excel-based example of how a Medicaid Reform Actuarial Equivalence Model might work. This prototype does not have the full functionality that a live version would have, but should provide an example of how the final model may be structured and how changes in scope, amount, and duration of services can be evaluated.

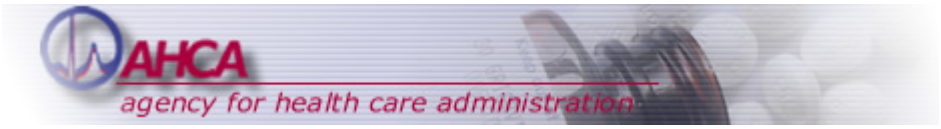
Throughout the model, items colored dark gray indicate that functionality is planned for the final model, but not included in the prototype. In addition, certain of the model tools have been built based on readily available data on similar populations in other states, adjusted to reflect key aspects of Florida's historical experience. The final live model is expected to be based on Florida experience entirely.

This model evaluates a proposed plan's actuarial equivalence to total historical Medicaid FFS experience (i.e., the proposed plan design is tested against the comprehensive and catastrophic components). This approach assumes the catastrophic component benefit design will be integrated with the comprehensive plan design and appropriate sufficiency thresholds established to ensure comparability between the catastrophic component of the proposed plan and the corresponding catastrophic level in historical Medicaid. If an integrated catastrophic plan design is not adopted, the actuarial equivalence approach used in this prototype will require revision.

Additional benefits not covered by historical Medicaid that may be offered by plans must be included in the actuarial equivalence calculations. This prototype model is established to accept inputs of PMPM values of any additional benefits, assuming that they are developed and provided by the proposing entity and accompanied by suitable supporting documentation.

Each worksheet in the model contains a box of "prototype commentary" that describes the purposes of the sheet and the refinements that could or should be included in a final version.

State of Florida Medicaid Reform Program - Plan Evaluation Model Prototype



Prototype Commentary: This User Input worksheet gathers information about the proposed plan: its targeted population, the geographic area in which it will be offered, and the benefit design.

A great deal of flexibility in benefit design will be accommodated in the final model, as shown in the benefit design input grid. The prototype provides examples of how annual benefit limits are evaluated for Total Inpatient Care, Total Prescription Drugs, and Outpatient Behavioral Health. It also provides examples of how co-pay differences can be evaluated, although the prototype does not value co-pays applied on a different basis than historical Medicaid (e.g., per day versus per admit). The prototype evaluates prescription drug limits on an annual basis against an unlimited benefit, whereas the current Florida Medicaid program has a monthly limit on brand name prescriptions.

Additional benefits (not historically covered by Medicaid) will be valued by the proposing entity and PMPM values input by AHCA into the model. The proposing entity will be required to submit supporting documentation to AHCA.

Step 1:

Enter Carrier Name	Florida Health Systems, Inc.
Enter Plan Name	Health Connections

Step 2:

Enter Contract Period

Contract Period

Begin Date (MM/DD/YY)	07/01/05
End Date (MM/DD/YY)	06/30/06

Step 3:

Select Target Population(s)

Population Target

Children and Families (Yes/No)	Yes
Aged and Disabled (Yes/No)	Yes

Step 4:

Select Target Region

Target Region	11
Pensacola Area	**1**
Tallahassee and Panama City Area	**2**
Gainesville and Ocala Area	**3**
Jacksonville and Daytona Beach Area	**4**
Clearwater/St. Petersburg Area	**5**
Tampa Area	**6**
Orlando Area	**7**
Ft. Myers Area	**8**
West Palm Beach Area	**9**
Ft. Lauderdale Area	**10**
Miami and Florida Keys	**11**

Step 5:
Enter Benefit Design Limits
PROTOTYPE IS RESTRICTED TO UNIT OR DOLLAR LIMITS (if both are input for same service dollar limit will be evaluated)
GRAY AREAS ARE NOT ENABLED IN PROTOTYPE
Benefit Design (Unit and Dollar Limits as Applied to Non-Pregnant Adults)

COVERED SERVICE CATEGORY	Covered for Adults	Covered for Children	Day/Visit Limit	Limit Period (Annual/Monthly)	Dollar Limit	Limit Period (Annual/Monthly)	Copay Amount	Copay Application
Inpatient Hospital	Y	Y	45	Annual		Annual		admit
Non-maternity Physical Health	Y	Y						
Maternity Care	Y	Y						
Behavioral Health	Y	Y						
Substance Abuse	Y	Y						
Skilled Nursing Facility	Y	Y						
Hospice	Y	Y						visit
Outpatient Hospital	Y	Y						visit
Physician Services	Y	Y						visit
Primary Care Physician	Y	Y						
Specialty Physician	Y	Y						
Physician Extender Services	Y	Y						visit
Pharmacy	Y	Y		Annual		Annual		script
Brand Pharmacy	Y	Y						
Generic Pharmacy	Y	Y						
Outpatient Therapy (PT/OT/ST)	Y	Y						visit
Outpatient Behavioral Health	Y	Y		Annual		Annual		visit
Outpatient Substance Abuse	Y	Y						visit
Home Health Services	Y	Y						visit
Lab Services	Y	Y						visit
Radiology	Y	Y						visit
Dental Services	Y	Y						visit
Vision Services	Y	Y						visit
Hearing Services	Y	Y						visit
Family Planning	Y	Y						
Durable Medical Equipment	Y	Y						
Transportation	Y	Y						trip

Prototype Commentary: This worksheet reports the results of the proposed plan evaluation for the Aged & Disabled Population. The report has 3 pages: Page 1 is the Summary, which shows the final decision, the actuarial equivalence percentage, and any sufficiency thresholds that were failed. Page 2 shows the sufficiency comparison detail, and Page 3 shows the actuarial equivalence comparison detail.

It is important to note that the sufficiency thresholds in this prototype are **examples**. Actual services to be evaluated are still subject to finalization, and appropriate thresholds will be developed as part of a detailed study of high cost claims and the catastrophic premium development.

In this prototype, the proposed plan is assumed to pass the actuarial equivalence test if it falls within 3 percent of the value of the historical Medicaid plan. The ultimate level of tolerance that will be used in plan evaluation is still not determined, but is expected to be small.

Proposed Plan Evaluation Report

Plan Name:	Florida Health Systems, Inc.: Health Connections	
Target Region:	Area 11	
Target Population:	Aged and Disabled	
Effective Date	7/1/2005	
AHCA Plan Approval Decision	**PASS**	
Actuarial Equivalence Results	**PASS**	101% of value of historical Medicaid benefits included in proposed plan
Benefit Sufficiency Results	**PASS**	All Sufficiency Thresholds Met

Prototype Commentary: This worksheet reports the results of the proposed plan evaluation for the Children and Families Population. The report has 3 pages: Page 1 is the Summary, which shows the final decision, the actuarial equivalence percentage, and any sufficiency thresholds that were failed. Page 2 shows the sufficiency comparison detail, and Page 3 shows the actuarial equivalence comparison detail.

It is important to note that the sufficiency thresholds in this prototype are **examples**. Actual services to be evaluated are still subject to finalization, and appropriate thresholds will be developed as part of a detailed study of high cost claims and the catastrophic premium development.

In this prototype, the proposed plan is assumed to pass the actuarial equivalence test if it falls within 3 percent of the value of the historical Medicaid plan. The ultimate level of tolerance that will be used in plan evaluation is still not determined, but is expected to be small.

Proposed Plan Evaluation Report

Plan Name:	Florida Health Systems, Inc.: Health Connections	
Target Region:	Area 11	
Target Population:	Children & Families	
Effective Date	7/1/2005	
AHCA Plan Approval Decision	**PASS**	
Actuarial Equivalence Results	**PASS**	100% of value of historical Medicaid benefits
Benefit Sufficiency Results	**PASS**	All Sufficiency Thresholds Met

Appendix V:
Recommendations for Earning Enhanced Benefit Credits
Florida Agency for Health Care Administration

The purpose of this report is to provide recommendations for healthy practices and/or behaviors that could be the basis for earning a deposit into an Enhanced Benefit Account for a Florida Medicaid enrollee under the State's proposed redesign. Based on a preliminary evaluation of the program objectives, the state has identified the below listing of proposed practices and/or behaviors that an individuals could undertake. The activities were selected to encourage participation and administrative simplicity with a view towards things that can be documented by someone in the system without having to establish an overly complex monitoring system to track each individual's claims to an EBA deposit.

The Enhanced Benefit Panel will review the identified activities and develop recommendations regarding approved services, potential value, and activities covered. The list may be expanded or contracted based on the panel's evaluation.

1. On a yearly basis, the custodial parent takes her child to the primary care provider for all screenings and immunizations at the age appropriate time.

2. Parents with children between the ages of 4-18 make and keep appointments for an annual dental exam for their children.

3. Parents with children between the ages of 3-6 make and keep an appointment for a vision-screening exam.

4. Parents with children between the ages of 3-18 make and keep an appointment for a yearly comprehensive well child-visit.

5. The member maintains active participation in a disease management program relevant to a current or potential health problem, e.g. diabetes, heart, obesity.

6. The member completes a smoking cessation program (Note: this is not pegged to actually quitting since that is impossible to monitor. Rather it is designed to encourage participation in any number of smoking cessation programs like those offered by the American Cancer Society).

7. The member completes a weight loss program (Note: for example, the member enrolls in weight watchers and earns a gold key which means they have met goal and maintained it for at least six weeks or engages in a physician monitored weight loss program).

8. The member completes and signs a living will or advance directives regarding their wishes in the event of a catastrophic illness.

9. The member plays a sport in an organized entity that can be documented, e.g. YMCA, city league, etc.

10. For the elderly and disabled, the member participates in an appropriate exercise program, e.g. mall walking, gym-sponsored program.

11. The member enrolls her child in an organized sport, e.g. gymnastics, softball, etc.

12. Members, when recommended by their physician, get a yearly flu shot.

13. Members with an on-going drug regiment fill and refill their prescriptions timely.

14. For members with an alcohol and/or drug issue, the member enrolls and is an active participant in an appropriate treatment program.

15. Adult members schedule and keep appointments for age appropriate screenings, e.g. mammograms, pap smears, colorectal screenings.

Once these behaviors have been agreed upon and the development of rates has progressed further, the next step will be to determine an appropriate value to assign to the behaviors and to begin developing a detailed description of how these accounts will be managed.

Appendix VI:
List of Mandated Health Insurance and HMO Benefits

The term “mandatory health insurance benefits” is subject to different interpretations. Broadly interpreted to include any coverage requirement, mandatory benefits include: (1) required policy benefits; (2) required offer of benefits; (3) required payment to a class of providers; and (4) required coverage of insureds and other underwriting restrictions. Florida has currently mandated health benefits for each of these categories be as follows:

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
1.	Acupuncturists	If a policy provides coverage for acupuncture, the policy must cover the services of an acupuncturist certified pursuant to chapter 457 under the same conditions that apply to services of a licensed physician.	627.6403	627.6618 Small group: 627.6699(12)(b)7	Not required	Not Required	Not Required
2.	Ambulatory Surgical Centers	A policy must provide coverage for any service performed in an ambulatory surgical center, as defined in s. 395.002, if such service would have been covered as an eligible inpatient service.	627.6056	627.6616 Small group: 627.6699(12)(b)7	Not required	Not Required	627.6616
3.	Birthing Centers and Nurse Midwives	A policy or HMO contract that provides coverage for maternity care must cover the services of certified nurse midwives and midwives licensed under chapter 467, and birth centers licensed under ss. 383.30-383.335.	627.6406	627.6574 Small group: 627.6699(12)(b)7	641.31(18)	627.6515(2)(c)	627.6699(12)(b)7
4.	Bone Marrow Transplants	The policy may not exclude coverage for bone marrow transplant procedures recommended by referring and treating physicians under a policy exclusion for experimental or investigative procedures if the particular use of the procedure is determined to be accepted within the appropriate oncological specialty and not experimental pursuant to rules adopted by the Agency for Health Care Administration, based on the recommendations of an advisory panel. Procedures must include costs associated with the donor-patient.	627.4236	627.4236	627.4236	Not required	627.4236 (But limited coverage provided in Standard)

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
5.	Cancer Drugs	If a policy covers the treatment of cancer, an insurer may not exclude coverage for any prescribed drug on the ground that the drug is not approved by the U.S. Food and Drug Administration, if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medial literature, unless the FDA has determined that the use of the drug is contra-indicated or has not otherwise approved the drug for any indication.	627.4239	627.4239	Not required	Not required	Not required
6.	Child Health Supervision Services	Policy benefits for children must include coverage for child health supervision services from birth to age 16 and be exempt from any deductible. Services include a physical examination, developmental assessment and anticipatory guidance, and immunizations and laboratory tests, consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.	627.6416	627.6579	641.31(30)	627.6515	627.6699(12)(b)4
7.	Children: Adopted and Foster Children	Benefits applicable to children apply to an adopted child and foster child from the moment of placement in the residence. Coverage begins at the moment of birth if a prior written agreement to adopt the child has been executed. The policy may not exclude coverage for any preexisting condition except in the case of a foster child. For HMOs and small group policies, only the benefits applicable to adopted children apply.	627.6415	627.6578 Small group: 627.6699(12)(b)4 (adopted only)	641.31(17) (adopted only)	Not required	627.6578(12)(e)
8.	Children: Handicapped	Policies covering children must continue to provide coverage beyond the age limit for dependent children as long as the child continues to be incapable of self-sustaining employment due to mental retardation or physical handicap; and is chiefly dependent on the policyholder or subscriber for support.	627.6615	627.6578 & 627.6615 Small group: 627.6699(12)(b)4	641.31(29)	Not required	627.6699(12)(b)4
9.	Children: Newborn Coverage	Policies covering a family member of the insured must provide coverage for a newborn child from the moment of birth. The policy must also cover the newborn child of a covered family member (son or daughter), which coverage terminates 18 months after birth.	627.641	627.6575 Small group: 627.6699(12)(b)4	641.31(9)	627.6515(2)(c)	627.6699(12)(b)4

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
10.	Children: Dependent Coverage to Age 25	Group health insurance policies that insure dependent children must continue coverage at least until the end of the calendar year in which the child reaches age 25 if the child is dependent upon the policyholder or certificate holder for support and the child is either living in the household of the certificate holder or is a full-time or part-time student.	Not required	627.6562	Not required	Not required	Not required (But included in the policy)
11.	Chiropractors	A health insurance policy must be construed to include payment to a chiropractic physician who provides covered benefits or procedures within the scope of his or her license. (Not applicable to HMOs.)	627.419(4)	627.419(4) Small group: 627.6699(12)(b)7	Not required	627.419(4)	627.6699(12)(b)7
12.	Cleft Lip/Palate for Children	Policy benefits for a child under age 18 must include treatment of cleft lip and cleft palate, including medical, dental, speech therapy, audiology, and nutrition services if prescribed by the treating physician or surgeon and certified as medically necessary.	627.64193	627.66911 Small group: 627.6699(12)(b)7	641.31(35)	627.6515(2)(c)	627.6699(12)(b)7
13.	Continuation of Group Coverage	Group policies covering fewer than 20 employees must allow an employee to continue coverage for 18 months (or 29 months for handicapped individuals; 36 months for divorced and widowed spouses) after their group coverage would otherwise terminate, subject to payment of up to 115% of the group premium. (Comparable to the federal COBRA law for employers with 20 or more employees.)	Not required	Small group: 627.6692	Small group: 627.6692	Not required	Small group: 627.6692
14.	Continued Coverage with Terminated Provider	If a contract between an HMO and a provider is terminated for any reason other than for cause, each party shall allow HMO subscribers for whom treatment was active, to continue coverage through completion of medically necessary treatment, until the subscriber picks another provider, or during the next open enrollment period offered by the HMO, not to exceed 6 months or through postpartum care if pregnant.	Not required	Not required	641.51(8)	Not Required	Not Required
15.	Conversion to Individual Coverage	After group coverage (large or small) terminates (after any COBRA extension), the insurer or HMO must offer an individual conversion policy.	Not required	627.6675	641.3921 & 641.3922	627.6515(2)(c)	Not required (But included in the policy)

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
16.	Denial of Coverage due to Breast Cancer	An insurer or HMO may not exclude or deny coverage solely because the insured has been diagnosed as having a fibrocystic condition or a nonmalignant lesion that demonstrates a predisposition to, or solely due to a family history of, breast cancer, unless the condition is diagnosed through a breast biopsy that demonstrates an increased disposition to developing breast cancer. Coverage also may not be denied nor canceled solely due to breast cancer if the insured has been free from breast cancer for more than 2 years before request for coverage.	627.6419	627.6419	627.6419	Not required	Not required
17.	Dental Care (Employer Offer of Open-Panel Plan)	Any employer, group, or organization that pays or contributes to the premiums of a group health plan or dental service plan which provides dental coverage only through an exclusive list of dentists must provide an alternative to enable the insured to have a free choice of dentist. (Note: This requirement applies to employers, not insurers.)	Not required	627.6577	Not required	Not Required	Not Required
18.	Dental Procedures for Children: General	If the policy provides coverage for general anesthesia and hospitalization services, such services must be provided for dental care to a person under age 8, if the dental condition is likely to result in a medical condition if left untreated and if the child's dentist and physician determine dental treatment in a hospital or ambulatory surgical center is necessary due to the complex nature of the procedure or due to a significant or undue medial risk.	627.4295	627.65755	641.31(34)	Not Required	Not Required
19.	Dentists	The word "physician" when used in a health insurance policy providing for the payment of surgical procedures performed in an accredited hospital in consultation with a licensed physician must be construed to include payment to a dentist who provides benefits or procedures within the scope of his or her license.	627.419(2)	627.419(2) Small group: 627.6699 (12)(b)7	Not required	627.419(2)	627.419(2)
20.	Dermatologists (Direct Access)	HMO contracts and insurer EPO contracts must provide direct access (without referral or authorization) for up to five office visits annually, including minor procedures and testing, to a dermatologist who is under contract with the insurer or HMO.	627.6472(16)	627.6472(16) & 627.662	641.31(33)	Not Required	Not Required

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
21.	Diabetes Treatment	Policy must cover all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the treating physician or a physician who specializes in the treatment of diabetes certifies that such services are necessary.	627.6408	627.65745	641.31(26)	Not Required	627.65745
22.a.	Emergency Care (EPO)	Insurers issuing exclusive-provider organization (EPO) contracts must cover non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.	627.6472	627.6472	Not Required	Not Required	Not Required
22.b.	Emergency Care (HMO)	HMOs must provide coverage, without prior authorization, for emergency care (screening and stabilization) based on determination by hospital physician or appropriate licensed professional hospital personnel under supervision of physician, provided by either a participating or nonparticipating provider.	Not required	Not required	641.513(3) & 641.31(12)	Not Required	641.513(3) & 641.31(12)
23.	Enteral Feeding Formulas/ Treatment of PKU	The policy must make available to the policyholder (e.g., to an employer under a group policy) as part of the application, for an appropriate additional premium, coverage for prescription and non-prescription enteral formulas (nutrient and food supplements) for home use which are prescribed by a physician as medically necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism or for malabsorption originating from congenital defects or acquired during the neonatal period. The coverage may not exceed $2,500 per year for an insured through age 24.	627.42395	627.42395	Not required	Not Required	Not Required
24.	Extension of Benefits	Group policy must provide for a 12-month extension of major medical benefits for a person who is totally disabled at the date of discontinuance of the policy, regardless of whether replacement coverage is obtained. Specific requirements apply to extension of benefits for maternity expense and dental procedures. (The requirements for dental procedures do not apply to HMOs.)	Not required	627.667	641.3111	627.6515(2)(c)	Not Required (But included in the policy)

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
25.	Guaranteed Availability of Individual Coverage (HIPAA-Eligible)	Persons who lose coverage after being covered for at least 18 months, the most recent of which is group coverage, are entitled to individual coverage. If the prior coverage is under an insured group plan, the group insurer must offer an individual conversion policy. If the prior coverage is with a self-insured plan, coverage may be obtained on a guaranteed-issue from any insurer or HMO issuing individual coverage. Persons who lose eligibility for individual coverage issued in Florida due to the insurer becoming insolvent, the insurer discontinuing all coverage in the state, or the individual moving out of the service area of the insurer or HMO, are entitled to guaranteed-issuance of coverage from any individual carrier.	627.6487	627.6487	627.6487	627.6487	627.6487
26.	Guaranteed Renewability	All individual and group policies and group HMO contracts must be guaranteed renewable, subject to certain exceptions.	627.6487	627.6571 Small group: 627.6699(7)	641.31074	627.6571 (Small group and bona fide associations)	627.6699(7)
27.	HIV Coverage	A policy may not exclude coverage for HIV-infection or acquired immune deficiency syndrome, except as provided in a preexisting condition exclusion.	627.411; 627.429	627.411; 627.429 Small group: 627.6699(6)(d)	641.3007	627.429	627.429 & 641.3007
28.	Home Health Care Services	A group policy must provide coverage of a least $1,000 per year for home health care by a licensed home health care agency, as prescribed by a licensed physician.	Not required	627.6617	Not required	Not Required	Not Required (But required in the policy)
29.	Mammograms	Policy must include coverage for a baseline mammogram for a woman age 35-39, a mammogram every two years for a woman age 40-49, every year for a woman age 50 or older, and one or more a year based on a physician's recommendation for a woman who is at risk for breast cancer based on specified criteria.	627.6418	627.6613 Small group: 627.6699(12)(b)4	641.31095	627.6515(2)(c)	627.6418 & 641.31095
30.	Massage Therapists	If a policy or HMO contract provides coverage for a massage, it must cover the services of a person licensed to practice massage under chapter 480, if the massage is prescribed as medically necessary by a physician licensed under chapters 458, 459, 460, or 461, and the prescription specifies the number of treatments.	627.6407	627.6619	641.31(37)	Not Required	Not Required

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
31.	Mastectomy: Length of stay and out-patient coverage	A policy that provides coverage for breast cancer may not limit in-patient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient. Must also provide coverage for outpatient post-surgical follow-up care in keeping with prevailing medical standards by a licensed health care professional qualified to provide such care.	627.64171	627.66121 Small group: 627.6699(12)(b)7	641.31(31)	627.6515(2)(c)	627.6699(12)(b)7
32.	Mastectomy: Surgical Procedures and Devices	If the policy provides coverage for a mastectomy, coverage must include prosthetic devices and breast reconstructive surgery incident to a mastectomy.	627.6417	627.6612 Small group: 627.6699(12)(b)7	641.31(32)	627.6515(2)(c)	627.6699(12)(b)7
33.	Maternity Care: Length of Stay and Post-Delivery Care	A policy that provides coverage for maternity benefits or newborn coverage may not limit coverage for length of stay in a hospital or for follow-up care outside of a hospital to any time period less than that determined to be medically necessary by the treating obstetrical care provider or the pediatric care provider, in accordance with prevailing medical standards. The policy must provide coverage for post-delivery care for the mother and infant, including medically necessary clinical tests and immunizations.	627.6406	627.6574 Small group: 627.6699(12)(b)7	641.31(18)	627.6515(2)(c)	627.6699(12)(b)7
34.	Mental and Nervous Disorders	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, for an appropriate additional premium, coverage for mental and nervous disorders. If mental health benefits are elected, coverage must include at least 30 days of in-patient coverage and at least $1,000 per year for outpatient benefits for consultations with a licensed physician, psychologist, mental health counselor, marriage and family therapist, and clinical social worker.	Not required	627.668 Small group: 627.6699(12)(b)7	627.668	Not Required	627.668 (But with different limits)

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
35.	Newborn Hearing Screening	Policies covering a family member of the insured must provide coverage for the initial hearing screening and any medically necessary follow-up reevaluations leading to diagnosis shall be a covered benefit. Medicaid recipients' services (including those in Medicaid HMOs or PSNs) will be reimbursed as fee-for-service (Medicaid rate) and other insurers will be reimbursed at the contracted rate.	627.6416	627.6579	641.31(30)	627.6515(2)(c)	627.6699(12)(b)4d
36.	Nurse Anesthetist	HMO contracts that provide anesthesia coverage or services shall offer to the subscriber if requested and available, the services of a licensed certified registered nurse anesthetist.	Not required	Not required	641.31(21)	Not Required	Not Required
37.	OB/GYN Annual Visit	Insurers issuing EPO contracts and HMOs must allow, without prior authorization, a female subscriber to visit a contracted OB/GYN for one annual visit and for medically necessary follow-up care detected at that visit.	627.6472(18)	627.6472(18) & 627.662	641.51(11)	Not Required	Not Required
38.	OB/GYNs	HMO must allow each female subscriber to select as her primary physician an obstetrician/gynecologist. (Also see Table 1, OB/GYN Annual Visit)	Not required	Not required	641.19(13)(e)	Not Required	HMO only: 641.19(13)(e)
39.	Ophthalmologist	Insurance policy and HMO contracts which provide coverage or services that are performed by physicians who are ophthalmologists, licensed under chapter 458 or 459, must offer the subscriber the services of an ophthalmologist.	627.419(2)	627.419(2)	641.31(20)	627.419(2)	627.6699(12)(b)7
40.a.	Optometrists	A health insurance policy that provides coverage for services within the scope of an optometrist's licenses shall be construed to include payment to an optometrist who performs such procedures.	627.419(3)	627.419(3) Small group: 627.6699(12)(b)7	Not required	627.419(3)	627.6699(12)(b)7
40.b.	Optometrists (HMO)	HMO contracts that provide coverage or services as described in s. 463.002(5), must offer to the subscriber the services of an optometrist licensed under chapter 463.	Not required	Not required	641.31(19)	Not Required	627.6699(12)(b)7

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
41.	Osteopathic Hospitals	Small employer policies and HMO contracts that provide for inpatient and outpatient services by allopathic hospitals must provide as an option for the patient or subscriber similar inpatient and outpatient services by an osteopathic hospital when the services are available in the HMO service area.	Not required	Small group only: 627.6699(12)(b)8	641.31(24)	Not required	Not required (But included in the policy)
42.a.	Osteopaths	For insurance policies a physician licensed under chapter 459 (osteopaths).	627.419(2)	627.419(2)	641.19(13)(d)	627.419(2)	Not required (But included in the policy)
42.b.	Osteopaths (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not required	Not required
43.	Osteoporosis Diagnosis and Treatment	Policy must provide coverage for the medically necessary diagnosis and treatment of osteoporosis for high-risk individuals, including individuals with a family history of osteoporosis and other specified high-risk criteria.	627.6409	627.6691	641.31(27)	Not Required	Not Required
44.	Out-of-Hospital Services	Policy must provide coverage for treatment provided outside a hospital if such treatment would be covered on an in-patient basis and is provided by a health care provider whose services would be covered under the policy if performed in a hospital.	627.4232	627.4232	Not required	Not Required	Not Required
45.a.	Podiatrists	A health insurance policy that provides coverage for services within the scope of a podiatrist's license shall be construed to include payment to a podiatrist who performs such procedures.	627.419(3)	627.419(3) Small group: 627.6699(12)(b)7	Not required	627.419(3)	627.6699(12)(b)7
45.b.	Podiatrists (HMO)	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not required	627.6699(12)(b)7

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
46.a.	Preexisting Conditions	Individual health insurance policies and individual HMO contracts may not exclude preexisting conditions for more than 24 months and may relate only to conditions that manifested themselves during the 24-month period before coverage. However, the policy may exclude coverage for named or specific conditions without any time limit.	627.6045 & 627.607	Not required	4-191.024(17) (Individual only)	Not required	Not required
46.b.	Preexisting Conditions	Group policies and group HMO contracts may not exclude preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee, and may relate only to conditions that manifested themselves during the 6-month period prior to coverage. The period of the exclusion is reduced by the time the insured was covered under prior creditable coverage.	Not required	627.6561	641.31071	Not required	627.6699(5)(f)
47.	Primary Care Physicians	For HMOs, a primary physician licensed under chapter 458 (allopathic physicians) or 459 (osteopaths), and chapters 460 (chiropractors) and 461 (podiatrists) must be designated for each subscriber upon request.	Not required	Not required	641.19(13)(e)	Not Required	Not Required
48.	Psycho-therapeutic Providers	An insurer issuing coverage through preferred providers (PPO policies) or through exclusive providers (EPO policies) that cover psychotherapeutic services, must provide eligibility requirements for all groups of health care providers licensed under chapter 458, 4359, 490 or 491, which include psychotherapy in their scope of practice, and certified advanced registered nurse practitioners in psychiatric mental health under s. 464.012.	627.6471 & 627.6472	627.6471, 627.6472 & 627.668	Not required	Not required	Not required
49.	Special Enrollment Periods	Insurers and HMOs issuing group health policies and contracts must: 1) allow an employee to enroll who previously did not enroll due to having other coverage, and the other coverage terminates due to certain conditions; 2) allow a person to enroll who becomes a dependent of a covered person by reason of marriage, birth, or adoption.	Not required	627.65615	641.31072	Not required	627.6699(5)(h)7

Benefit No.	Coverage Requirement	Summary	Individual Health Policies	Group Health Policies & Small Group Street Plans	HMO Contracts & Small Group Street Plans	Out of State Group	Standard & Basic (HMO & Ins.)
50.	Substance Abuse	Insurers and HMOs must make available to a group policyholder (e.g., the employer) as part of the application, specified benefits for substance abuse, subject to the right of the applicant to select any alternative benefits as may be offered. The specified level of benefits that must be offered must have a minimum lifetime benefit of $2,000, a maximum of 44 out-patient visits, and a maximum benefit of $35 per outpatient visit. Treatment must be provided by, or under the supervision of, or prescribed by, a licensed physician or psychologist.	Not required	627.669	627.669	Not Required	Not Required
51.	TMJ	A policy that provides coverage for any diagnostic or surgical procedure involving bones or joints of the skeleton may not discriminate against coverage for such procedures involving bones or joints of the jaw and facial region if such procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.	627.419(7)	627.65735	641.31094	627.6515(7)	Not Required (But included in the policy)

State of Florida
Jeb Bush, Governor

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Mission Statement

The Agency for Health Care Administration champions accessible, affordable, quality health care for all Floridians.