UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 05-23037-CIV-JORDAN/O'Sullivan

FLORIDA PEDIATRIC SOCIETY/THE FLORIDA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, et al.,

Plaintiffs,

vs.

ELIZABETH DUDEK, et al.,

Defendants.
_____/

SECRETARY DUDEK'S STATUS REPORT REGARDING IMPLEMENTATION OF PRIMARY CARE RATE INCREASES AND APPROVAL OF THE STATEWIDE MEDICAID MANAGED CARE WAIVER PROGRAM

Defendant, ELIZABETH DUDEK, in her official capacity as the Secretary of the Agency for Health Care Administration (AHCA), provides the following report regarding the status of implementation of rate increases for eligible primary care providers and the approval of the Statewide Medicaid Managed Care Waiver Program:

1. On April 1, 2013, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) approved the State Plan Amendment implementing the Affordable Care Act requirement that Medicaid pay eligible physicians increased payments for eligible services. Exhibit A.

2. CMS also provided comments on the self-attestation process required by 42 C.F.R. §447.400(a) (2013). Thereafter, AHCA implemented the self-attestation process for eligible Medicaid physicians and services provided on a fee-for-service (FFS) basis.

3. On April 9, 2013, AHCA issued a press release urging providers to submit their attestation for the primary care rate increase. Exhibit B. On April 15, 2013, AHCA issued a provider alert explaining that the attestation form was available for providers, and encouraging providers to visit the Florida Medicaid Web portal page. Providers were advised that they had until May 31, 2013 to complete the self-attestation process and obtain retroactive payments (back to January 1, 2013 for services provided prior to completion of the attestation process). Exhibit C.

4. On May 17, 2013, AHCA sent out a provider alert reminding providers that the Web portal attestation process and paper attestation form was available for eligible providers. The alert also reminded physicians that they had to self-attest to their eligibility for the rate increases by May 31, 2013, in order to receive retroactive enhanced reimbursement for eligible services provided on or after January 1, 2013, but prior to the completion of the self-attestation. Thereafter, the Medicaid fiscal agent was to complete a one-time reprocessing of claims for dates of service on or after January 1, 2013, but on or before May 31, 2013 (for providers who submitted their self-attestation by May 31, 2013). Exhibit D.

5. On March 29, 2013, AHCA submitted to CMS its required methodologies for implementing the primary care provider rate increase in Florida Medicaid Managed Care.[1] Exhibit E. On April 29, 2013, CMS sent to AHCA its questions based on the initial review of AHCA's managed care methodology submission. Exhibit F.

[1] / The methodologies are required pursuant to 42 C.F.R. §438.804(a)(1).

6. On June 24, 2013, AHCA submitted its responses to CMS' questions relating to the methodologies. Exhibit G. AHCA is awaiting CMS' approval of its methodologies. Once the methodologies are approved, AHCA will begin the process of making the retrospective payments to the managed care plans, which payments are necessary to comply with Section 1202 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §1202, 124 Stat. 1029, 1052-1053 (2010).[2]

7. AHCA has also been working with CMS to secure approval for a Statewide Integrated Medicaid Managed Care Program, to serve Florida's Medicaid population. AHCA has applied for an amendment to its existing Medicaid Reform Waiver (the authority for the waiver is 42 U.S.C. §1315, commonly referred to as section 1115), for this purpose. The state statutory authority for the Statewide Integrated Medicaid Managed Care Program is found at Sections 409.961-409.985, Fla. Stat. (2012). If approved, the program would operate in all Florida counties once fully implemented.

8. One aspect of the Statewide Medicaid Managed Care Program is the performance measure for physician compensation. Section 409.967(2)(a), Fla. Stat. (2012), provides:

> (a) Physician compensation.--Managed care plans are expected to coordinate care, manage chronic disease, and prevent the need for more costly services. ***Effective care management should enable plans to redirect available resources and increase compensation for physicians***. ***Plans achieve this performance standard when physician payment rates equal or exceed Medicare rates for similar services. The agency may impose fines or other sanctions on a plan that fails to meet this performance standard after 2 years of continuous operation***.

Therefore, participating Medicaid managed care plans achieve the physician compensation standard required by Section 409.967(2)(a) when their physician payment rates equal or exceed

[2] / The managed care plans must report to AHCA in an approved format, the information needed to determine the amount to be paid to each plan. Then AHCA will process the retrospective payments.

Medicare rates for similar services. If participating plans fail to meet this standard after 2 years of continuous operation, they are subject to sanctions.

9. On June 14, 2013, CMS approved AHCA's request to amend its section 1115 Medicaid Reform Demonstration project, which is now re-titled the Managed Medical Assistance Program. The approval is subject to an implementation plan and a determination of readiness based on the elements of that plan. The state is to implement the program on a staggered region-by-region basis no sooner than January 1, 2014 (but AHCA presently expects to implement the program beginning in April 2014). Exhibit H.

10. Additionally, the Fall 2012 State of Florida Long-Range Financial Outlook for Fiscal Years 2013-2014 through 2015-2016 includes $173.8 million in recurring General Revenue in Fiscal Year 2015-2016 to continue the Primary Care Practitioner Fee Increases that have been initiated under the Affordable Care Act, beyond December 31, 2014, through fiscal year 2015-2016. This has been identified in the report (adopted by the Florida Legislative Budget Commission[3]) as an "Other High Priority Need." Exhibit I.

11. AHCA will notify the Court as soon as CMS approves the methodologies related to the implementation of the primary care rate increase as referenced in paragraphs 5 and 6, supra.

[3] / The responsibility of the Legislative Budget Commission to develop the long-range financial outlook is described in Section 11.90(6)(b), Fla. Stat. (2012). The Commission is " composed of seven members of the Senate appointed by the President of the Senate and seven members of the House of Representatives appointed by the Speaker of the House of Representatives. § 11.90(1), Fla. Stat. (2012).

Respectfully submitted,

PAMELA BONDI
Attorney General

/s/ Stephanie A. Daniel
STEPHANIE A. DANIEL
Chief-Assistant Attorney General
State Programs Litigation
Fla. Bar No. 332305
Stephanie.Daniel@myfloridalegal.com
ALBERT J. BOWDEN, III
Senior Assistant Attorney General
Fla. Bar No. 0802190
Al.Bowden@myfloridalegal.com
CHESTERFIELD SMITH, JR.
Associate Deputy Attorney General
General Civil Litigation
Fla. Bar No. 852820
Chesterfield.Smith@myfloridalegal.com

Office of the Attorney General
PL-01, The Capitol
Tallahassee, Florida 32399-1050
Tel.: (850) 414-3300
Fax: (850) 488-4872
ROBERT D.W. LANDON, III
Fla. Bar No. 961272
rlandon@kennynachwalter.com

Kenny Nachwalter, P.A.
201 South Biscayne Boulevard
1100 Miami Center
Miami, Florida 33131-4327
Telephone: (305) 373-1000
Fax: (305) 372-1861

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing has been served by Notice of Electronic Filing on **Stuart H. Singer, Esq., Carl E. Goldfarb, Esq., Damien J. Marshall, Esq.**, and **Sashi Bach Boruchow, Esq.,** Boies, Schiller & Flexner LLP, 401 East Las Olas Blvd., Suite 1200, Fort Lauderdale, FL 33301, and by United States Mail on **Thomas K. Gilhool, Esq.**

and **James Eiseman, Jr., Esq.**, Public Interest Law Center of Philadelphia, 1709 Benjamin Franklin Parkway, Second Floor, Philadelphia, PA 19103; **Louis W. Bullock, Esq.**, Bullock, Bullock, & Blakemore, 110 W. 7th Street, Tulsa, Oklahoma 74112, and Robert D.W. Landon, III, Esquire, Kenny Nachwalter, P.A., 201 South Biscayne Boulevard, 1100 Miami Center, Miami, Florida 33131-4327, on June 25, 2013.

/s/ Stephanie A. Daniel
Stephanie A. Daniel

EXHIBIT "A"

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

April 1, 2013

Mr. Justin M. Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

RE: Title XIX State Plan Amendment, FL 13-002

Dear Mr. Senior:

We have reviewed the proposed State Plan Amendment, FL 13-002, which was submitted to the Atlanta Regional Office on January 2, 2013. This amendment implements the Affordable Care Act Section 1202 requirement that Medicaid pay physicians practicing in family medicine, general internal medicine, pediatric medicine, and related subspecialists at Medicare levels for the procedure codes specified in the Act for Calendar Years 2013 and 2014.

Based on the information provided, the Medicaid State Plan Amendment FL 13-002 was approved on April 1, 2013. The effective date of this amendment is January 1, 2013. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Sid Staton at (850) 878-3486 or Sidney.Staton@cms.hhs.gov.

Sincerely,

Nina Roberts for

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2013-002

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.405,447.410, 447.415

7. FEDERAL BUDGET IMPACT: (in thousands)
FFY 2012-2013 $ 524,119
FFY 2013-2014 $ 698,825

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B TBD
Attachment 4.19-B page 28

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B TBD
Attachment 4.19-B page 28

10. SUBJECT OF AMENDMENT: Primary Care Rate Increase

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Mr. Justin M. Senior

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED:
1-2-13

16. RETURN TO:
Mr. Justin M. Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308

Attention: April Cook

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 01-02-13

18. DATE APPROVED: 04-01-13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01-01-13

20. SIGNATURE OF REGIONAL OFFICIAL:
Gina Roberts for Jackie Glaze

21. TYPED NAME:
Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

Approved with the following changes to item 7, 8 and 9 as authorized by State Agency e-mail dated 03/28/13:

Block # 7 Changed to read: 7a –FFY 2012-2013 $306,764 and 7b – FFY 2013-2014 $409,019.

Block # 8 Changed to read: Attachment 4.19-B, pages, 28b, 28c, and 28d, Attachment 4.19-B page 28.

Block # 9 Changed to read: Attachment 4.19-B pages 28b, 28c and 28d new, Attachment 4.19-B page 28.

FORM HCFA-179 (07-92)

METHODS USED IN ESTABLISHING PAYMENT RATES

1/1/13 INDIVIDUAL PRACTITIONERS SERVICES - (Doctors of Medicine, Chiropractic, Osteopathy, Dentistry, Optometry and other individual Practitioners services) -
Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of physician, chiropractic, osteopathic, dental, optometric, and podiatric services. The agency's fee schedule rate is in effect for services provided on or after January 1, 2013. All rates, including current and prior rates, are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule including the Primary Care Rate Increase referenced in section 1902 (a) (13) (C) of the Social Security Act are published at www.MyMedicaid-Florida.com.

1/1/01 Medicaid will only reimburse doctors of medicine, osteopathy, and other individual practitioner services for mobile services under contractual agreement with a Federally Qualified Health Center or a County Health Department. Medicaid will only reimburse those practitioners whose mobile Rural Health Clinic (RHC) units are certified by Medicare as mobile RHCs in accordance with Title 42 Code of Federal Regulations.

Medicaid will only reimburse doctors of optometry for mobile services under contractual agreement with a Federally Qualified Health Center. Medicaid will only reimburse those practitioners whose mobile Rural Health Clinic (RHC) units are certified by Medicare as mobile RHCs in accordance with Title 42 Code of Federal Regulations.

7/1/01 Medicaid will only reimburse doctors of dentistry for mobile services under contractual arrangement with a Federally Qualified Health Center, County Health Department, state approved dental educational institution, or for services rendered to recipients age 21 and over at nursing home facilities.

Reimbursement for mobile services is made directly to the CHD, FQHC or RHC on a cost-based reimbursement method. Reimbursement to the individual practitioners contracting with these entities is made directly by the CHD, FQHC or RHC with whom they contract the services provided.

Medicaid will not reimburse for mobile services for radiology procedures or interpretations if the service was provided by a mobile provider.

Amendment 2013-002
Effective 01/01/2013
Supersedes 2012-014
Approval 04-01-13

Reimbursement Template -Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99288, 99316, 99358, 99359, 99363, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99466, 99467, 99485, 99486, 99487, 99488, 99489, 99495, 99496, 99499.

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

The state will make payment for 99224, 99225, and 99226. All three codes were added January 1, 2011.

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: _____.

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $10.00.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____
_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Florida Medicaid will be using the Deloitte fee schedule (which was based on the November 2012 Medicare release and the 2009 conversion factor). The state will not adjust the fee schedule to account for changes in Medicare rates throughout the year.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at:

The Florida Medicaid fiscal agent's Web site at www.mymedicaid-florida.com.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at

The Florida Medicaid fiscal agent's Web site at www.mymedicaid-florida.com.

EXHIBIT "B"

PRESS RELEASE

FOR IMMEDIATE RELEASE
April 9, 2013
Contact: AHCA Communications
(850) 412-3623

Agency Urges Physicians to Submit their Attestation for Primary Care Rate Increase
Providers have until the end of May to attest back to 01/01/2013

Tallahassee, Fla.— The Agency for Health Care Administration (Agency) is encouraging eligible physicians to submit their attestation to the Agency by May 31 in order to receive the primary care rate increase. The Agency will begin reprocessing claims in June with dates of service from 01/01/2013 to the present for those providers who have attested.

For faster processing, providers are encouraged to utilize the electronic attestation form. For providers without access to the secure Web Portal, a paper attestation form is available on the public Web Portal, mymedicaid-florida.com, by selecting Enrollment > Enrollment Forms >Certification and Attestation for Primary Care Rate Increase.

"It is very important that providers get these forms in as soon as possible to start receiving payments in June," said Justin Senior, Medicaid Director. "We want to make this process as seamless as possible."

Once a physician submits the attestation online their provider file will be immediately updated and any claims that process after that time will receive the enhanced rate. Providers should visit the Agency's website to access an Instructional Guide for completing the attestation form<http://click.icptrack.com/icp/relay.php?r=18230974&msgid=645757&act=JG3A&c=227375&destination=http%3A%2F%2Fportal.flmmis.com%2FFLPublic%2FPortals%2F0%2FStaticContent%2FPublic%2FPublic%2520Misc%2520Files%2FInstructional%2520Guide%2520for%2520Completing%2520the%2520Attestation%2520Form%2520v7.pdf>.

Click Here<http://click.icptrack.com/icp/relay.php?r=18230974&msgid=645757&act=JG3A&c=227375&destination=http%3A%2F%2Fportal.flmmis.com%2FFLPublic%2FPortals%2F0%2FStaticContent%2FPublic%2FPublic%2520Misc%2520Files%2FAffordable_Care_Act_Primary_Fee_Increase_Reference_Guide.pdf> for more information about the Affordable Care Act Primary Care Rate increase.

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 45,000 health care facilities and 37 health maintenance organizations, and publishes health care data and statistics at www.FloridaHealthFinder.gov<http://click.icptrack.com/icp/relay.php?r=18230974&msgid=645757&act=JG3A&c=227375&destination=http%3A%2F%2Fwww.floridahealthfinder.gov%2F>.

EXHIBIT "C"

Providers

- **Home**
- **Area Offices**
- **Contact Us**
- **Provider Support**
  - **Provider Bulletins**
  - **Provider Notices**
  - **Provider Handbooks**
  - **Provider Alerts**
  - **Fee Schedules**
  - **Forms**
  - **Recipient Notices**
  - **Training**
  - **FAQ**
- **Medicaid Electronic Health Record (EHR) Incentive Program**
- **Enrollment**
- **EDI**
- **Managed Care**
- **Pharmacy**
- **TPL**

Agency Initiatives

- **DRG Pricing**
- **ICD-10**

Provider Message Archive

Periodically, the state Medicaid office will communicate to the provider community via provider alert messages. Provider alerts typically contain new policies and/or pertinent Medicaid information relevant to the provider community. This page contains recent and historical Medicaid provider alerts.

Archived messages may contain links to websites or documents that no longer exist at the linked URL. Documents referenced in the messages that are maintained by the fiscal agent can be found within the public pages of the HP Web Portal.

To subscribe to receive Provider Alerts, complete the online form on the Florida Medicaid Health Care Alerts page.

To search for a specific alert, enter a keyword and click the "search" button. To view all alerts, click the "search" button below.

Provider Message Archive

Keyword	PRIMARY
Year	2013
Provider Type	25 - PHYSICIAN (M.D.)
Specialty	
Records	20

Messages

Type/Specialty	Sent Date	Subject
PHYSICIAN (D.O.), PHYSICIAN (M.D.)	05/20/2013	Affordable Care Act Primary Care Rate Increase
PHYSICIAN (D.O.), PHYSICIAN (M.D.)	05/20/2013	Primary Care Rate Increase Vaccine Administration Codes
PHYSICIAN (D.O.), PHYSICIAN (M.D.)	04/24/2013	Affordable Care Act (ACA) Primary Care Fee Increase for Vaccine Administration-Update
PHYSICIAN (D.O.), PHYSICIAN (M.D.)	04/15/2013	Affordable Care Act Primary Care Fee Increase
PHYSICIAN (D.O.), PHYSICIAN (M.D.)	04/15/2013	Affordable Care Act Primary Care Fee Increase for Vaccine Administration
CASE MANAGEMENT AGENCY, COMMUNITY BEHAVORIAL HEALTH SERVICES, COUNTY HEALTH DEPARTMENT, FEDERALLY QUALIFIED HEALTH CENTER, HMO, HOME & COMMUNITY-BASED SERVICES WAIVER, PHYSICIAN (D.O.), PHYSICIAN (M.D.), PREPAID MENTAL HEALTH SERVICES, PROFESSIONAL EARLY INTERVENTION SERVICES, SPECIALIZED MENTAL HEA	02/05/2013	Optional Request Form for Prior Authorization of Applied Behavior Analysis for Children with Autism

Message

Type/Specialty PHYSICIAN (D.O.)
PHYSICIAN (M.D.)

Subject Affordable Care Act Primary Care Fee Increase

Information Update

The Agency for Health Care Administration is pleased to announce that the Web portal attestation process and paper attestation form is available for providers. Providers are encouraged to visit the Florida Medicaid Web portal page for information on the primary care fee increase. This fee increase is in accordance with the Patient Protection and Affordable Care Act (ACA) for eligible Medicaid-enrolled physicians who provide primary care services. Eligible physicians must self-attest in order to receive the enhanced reimbursement.

Retroactive Reimbursement/Claims reprocessing

Physicians who complete the self-attestation process prior to May 31, 2013 will be eligible for the rate increase retroactively to January 1, 2013. The Medicaid fiscal agent will complete a one-time reprocessing of claims after May 31, 2013 for dates of service on or after January 1, 2013. Physicians who self-attest after May 31, 2013 are eligible for the increase on the first day of the month of self-attestation, and may reprocess/adjust claims retroactively to the first of the month.

Message

Fee schedule

A fee schedule with the enhanced rates for the Current Procedural Terminology (CPT) codes is available on the provider web portal and will be effective January 1, 2013 for eligible providers.

Managed care providers

Providers under Florida Medicaid health plan contracts are eligible for the fee increase.

Effective Date 04/15/2013

Sent Date 04/15/2013

Disclaimer

EXHIBIT "D"

Providers

- **Home**
- **Area Offices**
- **Contact Us**
- **Provider Support**
  - **Provider Bulletins**
  - **Provider Notices**
  - **Provider Handbooks**
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  - **Fee Schedules**
  - **Forms**
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Specialty	
Records	20

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PHYSICIAN (D.O.), PHYSICIAN (M.D.)	05/20/2013	Primary Care Rate Increase Vaccine Administration Codes
PHYSICIAN (D.O.), PHYSICIAN (M.D.)	04/24/2013	Affordable Care Act (ACA) Primary Care Fee Increase for Vaccine Administration-Update
PHYSICIAN (D.O.), PHYSICIAN (M.D.)	04/15/2013	Affordable Care Act Primary Care Fee Increase
PHYSICIAN (D.O.), PHYSICIAN (M.D.)	04/15/2013	Affordable Care Act Primary Care Fee Increase for Vaccine Administration
CASE MANAGEMENT AGENCY, COMMUNITY BEHAVORIAL HEALTH SERVICES, COUNTY HEALTH DEPARTMENT, FEDERALLY QUALIFIED HEALTH CENTER, HMO, HOME & COMMUNITY-BASED SERVICES WAIVER, PHYSICIAN (D.O.), PHYSICIAN (M.D.), PREPAID MENTAL HEALTH SERVICES, PROFESSIONAL EARLY INTERVENTION SERVICES, SPECIALIZED MENTAL HEA	02/05/2013	Optional Request Form for Prior Authorization of Applied Behavior Analysis for Children with Autism

Message

Type/Specialty	PHYSICIAN (D.O.) PHYSICIAN (M.D.)
Subject	Affordable Care Act Primary Care Rate Increase

The Agency for Health Care Administration wishes to remind Medicaid enrolled physicians that the Web portal attestation process and paper attestation form is available for eligible providers.

Physicians are encouraged to visit the Florida Medicaid Web portal page for information on the primary care fee increase. Eligible physicians must self-attest in order to receive the enhanced reimbursement.

Retroactive Reimbursement/Claims reprocessing

Message	Physicians MUST attest on or before May 31, 2013, in order to receive retroactive reimbursement for dates of services beginning January 1, 2013. Physicians who self-attest after May 31, 2013 are eligible for the increase on the first day of the month of self-attestation, and may adjust claims retroactively to the first of the month. Physicians who complete the self-attestation process prior to May 31, 2013 will be eligible for the rate increase retroactively to January 1, 2013. The Medicaid fiscal agent will complete a one-time reprocessing of claims after May 31, 2013 for dates of service on or after January 1, 2013. **Managed care providers** Providers under Florida Medicaid health plan contracts are eligible for the fee increase. More information will be provided to managed care providers at a later date.
Effective Date	05/20/2013
Sent Date	05/20/2013
Disclaimer	The information contained in this message is confidential and is intended solely for the use of the person or entity named above. This message may contain individually identifiable information that must remain confidential and is protected by state and federal law. If the reader of this message is not the intended recipient, the reader is hereby notified that any dissemination, distribution or reproduction of this message is strictly prohibited. If you have received this message in error, please immediately notify the sender by telephone and destroy the original message. We regret any inconvenience and appreciate your cooperation.

EXHIBIT "E"

From: Macdonald, Linda
Sent: Friday, March 29, 2013 5:06 PM
To: Brimage, Cheryl L. (CMS/CMCHO); Etta Hawkins (etta.hawkins@cms.hhs.gov); Sidney Staton (Sidney.staton@cms.hhs.gov); Terry Frix (TERRY.FRIX@cms.hhs.gov); Reed, Steve M. (CMS/CMCHO) (STEVE.REED@cms.hhs.gov); Maria.Sotirelis@cms.hhs.gov; Holly, Mary V. (CMS/CMCHO) (Mary.Holly@CMS.hhs.gov); Cieslicki, Mary E. (CMS/CMCS) (Mary.Cieslicki@cms.hhs.gov)
Cc: Senior, Justin; Lampkin, Stacey; Rogers, David; Kidder, Beth; Sokoloski, Kristin; Chang, Karen; Wallace, Thomas J.; Harris, Shevaun; Brown-Woofter, Melanie; McCullough, Mary; Bolin, Michael; Royce, David; Williams, Stuart; Cofer, Eleanor; Vergeson, Melissa
Subject: Methodology for Implementing PCP Increase in Florida Medicaid Managed Care

Etta/Cheryl,

Please find attached our methodology for implementing PCP increase in Florida Medicaid Managed Care. If you have questions regarding the methodology, please contact Stacey Lampkin or Karen Chang.

Stacey Lampkin, Acting Assistant Deputy Secretary for Medicaid Finance
Phone: 850-412-4798
Email:
Stacey.Lampkin@ahca.myflorida.com<mailto:Stacey.Lampkin@ahca.myflorida.com>

Karen Chang, Chief of the Bureau of Medicaid Program Analysis
Phone: 850-412-4075
Email: Karen.Chang@ahca.myflorida.com<mailto:Karen.Chang@ahca.myflorida.com>

Thanks, Linda

From: Brimage, Cheryl L. (CMS/CMCHO) [mailto:Cheryl.Brimage@cms.hhs.gov]
Sent: Thursday, March 28, 2013 2:15 PM
To: Macdonald, Linda
Subject: PCP Bump Methodology

Linda,

Do you know the status of Florida's PCP bump methodology that must be submitted to CMS NLT the end of this month?

Thanks

Cheryl L. Brimage, MHA
Health Insurance Specialist
Division of Medicaid & Children's Health Operations
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303
Phone: 404-562-7116
Fax: 443-380-5901

Methodology for Implementing Primary Care Fee Increase in Florida Medicaid Managed Care

Background

Section 1202 of the Affordable Care Act (ACA) requires state Medicaid agencies during calendar years 2013 and 2014 to pay primary care physicians at least Medicare fee levels for certain E&M and immunization services. The federal government will match at 100% the increased cost between Medicaid 2009 fee levels and the required Medicare level for this 24 month period. The fee increase is required in both fee-for-service (FFS) payments and capitated managed care programs. The Centers for Medicare and Medicaid Services (CMS) published a final rule regarding implementation of this required fee increase on November 1, 2012 and additional technical guidance with respect to managed care implementation on January 8, 2013. This methodology document is designed to outline Florida's proposed approach for managed care implementation to meet the methodology submission requirements outlined in the new rule.

Physician Payment in Florida Medicaid

Florida Medicaid physician fee schedules are based on a resource based, relative value scale (RVU) methodology as authorized in s. 409.908(12), Florida Statutes, with an applied conversion factor, and specific appropriations for increased reimbursement for pediatric services. The RVU/Conversion Factor process results in "base fees" established at the procedure code level. Through the appropriation process, base fees have two "adjustors" that can be applied under the specified circumstances for the lists of E&M codes referenced in the ACA. Services provided to recipients under age 21 have a multiplier of 1.04 to determine the appropriate fee. Services provided by certain physician specialties have a multiplier of 1.24. Both multipliers are applied when a physician with one of the designated specialty types provides a specified service to a child. Procedure codes 99212, 99213, and 99214 do not have multipliers, but are paid an appropriated amount that is a higher reimbursement rate for primary care evaluation and management services for recipients aged 0-19. Base fees are paid to physicians who do not have one of the designated specialty types when they provide services to an adult. Physician extenders are paid at 80% of the physician fee level.

In Florida Medicaid, benefits coordination with Medicare is based on a reimbursement rule that compares the amount already paid by Medicare (and other third party payers, if any) to the Medicaid fee that would have applied had Medicaid been the primary payer and the recipient's Medicaid copay. If the amount already paid exceeds the applicable Medicaid fee minus copay, then no payment is made by Medicaid. If the amount paid does not exceed the applicable Medicaid fee minus the copay, Medicaid pays the recipient deductible/coinsurance up to the value of the Medicaid fee minus the copay. The federally-required Medicaid primary care fee increase means that many more of these "crossover"

claims will produce a non-zero payment from Medicaid, and the amounts paid will increase as the coordination logic compares to a higher Medicaid fee.

Medicaid Managed Care in Florida

The Agency for Health Care Administration (the Agency or AHCA), the single state Medicaid agency, currently manages a complex delivery system, comprised of several forms of managed care. Plans may be either Health Maintenance Organizations (HMOs) or Provider Service Networks (PSNs), and PSNs may be either fee-for-service (FFS PSNs) or capitated (CPSNs). The Agency also administers a primary care case management program, known as MediPass. The following managed care programs generally do not cover primary care services, and thus are not addressed in this document:

- Pre-paid dental plans
- Pre-paid mental health plans
- D-SNPs[1]

AHCA will implement the fee increase for FFS claims as an updated fee schedule that applies only to qualified providers and procedures. As a result, FFS claims will be paid at the Medicare rate as a part of the regular payment process. Medicare fee levels will be based on the non-facility setting fees, rather than setting-specific fees. Florida will follow the geographic payment approach used by Medicare. The Agency intends to update the Medicare fee levels annually based on the Medicare physician fee schedule released in November of each year, and will not incorporate any mid-year updates to Medicare fee levels.[2] This FFS approach will apply to services provided to MediPass enrollees, enrollees in a FFS PSN, and other recipients not enrolled in an acute care pre-paid plan. The remainder of this document addresses the methodology that will be used to adjust payments to capitated plans and identify the portion of those payments eligible for enhanced match, for the following pre-paid programs that include primary care services:

- Non-Reform capitated plans (HMOs and CPSNs)
- Reform capitated plans (HMOs and CPSNs)
- Frail Elder Program
- Nursing Home Diversion
- PACE

Over the next two years, Florida expects to begin implementation of its new Statewide Medicaid Managed Care (SMMC) program, as directed by ss. 409.961 through 409.985, F.S. The new program will streamline delivery of services to Medicaid recipients, and many of the existing managed care programs will sunset. Long-Term Care (LTC) managed care plans will begin enrollment during 2013 and the Managed Medical Assistance (MMA) plans, providing acute care services, will begin enrollment during

[1] D-SNP products do include Medicaid responsibility for member cost sharing associated with primary care services; however, D-SNP rate development starts with a standard assumption that primary care services are paid at Medicare levels, thus, no adjustment/increase is necessary.

[2] Per federal requirements, the conversion factor used will be the greater of the 2009 conversion factor or the current factor.

2014. It is expected that the primary care fee increase will not affect the LTC capitation rates. The general methodology that will apply to the MMA plans is expected to be very similar to that described here for the current Reform and Non-Reform health plans. If an alternative methodology is determined to be appropriate for the new program, an updated methodology document will be provided to CMS.

Proposed Methodologies

The structure of this section follows the requirements of the CMS Technical Guidance document provided to States January 8, 2013. As directed in that guidance, sections are included describing the risk model to be used, the calculation of the 2009 base rate, the calculation of the 2013 (2014) payment differential, and the calculation of the increment that qualifies for 100% FFP.

I. Risk Model

The Agency proposes to use a **non-risk reconciled payment model** for reimbursing managed care plans for their additional expenses related to the required PCP fee increase. Given the complexity of the managed care program in Florida, this model provides the most accurate method to ensure that funds flow appropriately through the managed care plans to the eligible providers. In general, this model will mimic the FFS approach described on page 2. That is, Medicare fee levels will be updated annually, and they will be based on the non-facility setting fee. Geographic adjustments will be used.

Each quarter, plans will submit a utilization report for primary care services that were paid on behalf of their Medicaid enrollees in the prior quarter. Reports will be due by the last day of the first month after the quarter has ended (e.g., April 30 for the quarter ending March 31). Only services that are eligible for the fee increase will be reported, based on the qualifications of the provider and the procedure codes identified by law. This report will be at the procedure code level, and segmented by key characteristics needed to support the calculations described in Sections III and IV of this document. Characteristics needed to assign the applicable Medicare fee include Medicare geographic region and provider type (physician or physician extenders). Characteristics related to capitation rates and the fee levels that underlie them are the applicable AHCA geographic region, rate group (e.g., TANF, SSI), child/adult, and month of service. See attached example. The plans will also provide the Agency with a list of the encounters that back up the utilization summarized in the report.

AHCA will review the quarterly reports, and apply the procedure code payment differential that is described in Section III below. Each plan will receive a lump sum payment reflecting the total value of the payment differential. Plans will then distribute the funds to the eligible providers. These quarterly reports will continue through December 31, 2015, covering services provided during calendar years 2013 and 2014, to ensure that all eligible service claims run-out is captured and reimbursed.

II. Calculation of 2009 Base Rate

For the non-risk reconciled payment model approach, the relevant 2009 base rate is the physician fee level (average unit cost) that was used in the development of the capitation rates that were in effect on July 1, 2009. For all the capitated programs in Florida Medicaid, capitation rates that were in effect in on July 1, 2009, were developed using historical FFS data. The rates were developed to be effective for the

period September 1, 2008 – October 2009. No encounter data or plan financial reports were utilized in these rate development processes. Service adjustments applied to the FFS data were applied in the form of utilization and unit cost "inflation factors" that incorporate both trend effects and any necessary program changes. The unit cost inflation factors are designed to convert the historical FFS fee levels to the fee levels in effect during the rate period. Thus, for all managed care programs, the unit costs on which the 2009 capitation rates were based were the FFS fee schedules in effect at that time. Additional factors were applied in the rate setting process to represent the net effects of managed care and administrative load, but those factors did not adjust expected utilization or unit costs of primary care services. For more information on the SFY 2008-2009 rate development process, please see the rate certification reports submitted to CMS.

III. Calculation of the Primary Care Payment Differential

The capitation rates that plans receive during calendar years 2013 and 2014 include some assumed physician payment levels, which generally will not be equal to the 2009 base levels described in the preceding section. The increased primary care payments that AHCA will make to plans each quarter must reflect the differential between the fee levels assumed in the capitation rates in effect for the date of service and the required Medicare fee levels. For all programs, the rate period runs from September 1 through August 31. This means that the primary care fee increase methodology will span three rate periods, as shown in the table below.

Rate Agreement Period	Applicable PCP Fee Increase
September 1, 2012 – August 31, 2013	2013 Medicare Rates used for January – August 2013 services
September 1, 2013 – August 31, 2014	2013 Medicare Rates used for September – December 2013 services 2014 Medicare Rates used for January – August 2014 services
September 1, 2014 – August 31, 2015	2014 Medicare Rates used for September – December 2014 services

Payment differentials will be calculated at the procedure code level separately for each program, based on the methodology used for development of the physician services component of the main capitation rates. A number of programs and/or rate groups currently use historical FFS data in rate development, as described in Section II for the 2009 capitation rates. In those cases the rate development process generally produces a rate that reflects current FFS payment levels. However, in both Reform and Non-Reform, the base data used for capitation rates is built using several underlying data sources, according to which data sources at this time provide the best basis for understanding the utilization and cost profile of the covered population for the particular type of service. For enrollees dually eligible for Medicaid and Medicare and enrollees in HIV/AIDs specialty plans, fee-for-service claims history is used for all services. For Medicaid-only enrollees in standard (non-specialty) plans, the physician services component is a blend of FFS data and health plan experience as reflected through financial reports. The Nursing Home Diversion program has also progressed to using encounter data in the rate development process. Rate development methodologies that utilize historical health plan experience, such as these, may produce underlying fee levels that vary somewhat from current FFS Medicaid fee levels. For each of

the three rate periods shown in the table above, the Agency and its actuaries will identify the average primary care unit cost that underlies the capitation payments for each program and rate group. To understand the influence plan experience has on these unit costs, primary care payment levels reported on plan encounter data will be evaluated. A schedule of results by procedure code with an explanatory narrative will be provided to CMS for each rate period.

Each quarter, based on the utilization reported by rate cell characteristics, the Agency will compare the applicable Medicare fee to the underlying fee assumed in the applicable capitation rate to calculate the payment differential for each procedure code. A lump sum payment will be made to each plan equal to the sum of the payment differential for all codes. See the attached example.

IV. Calculation of the Increment Eligible for 100% FFP

The final step each quarter will be the calculation of the payment increment that is eligible for 100% FFP. The enhanced FFP is based on the difference between the applicable Medicare fee and the 2009 base fee, for each unit of primary care service provided by a qualified provider. Because the quarterly increased payment made to the health plan is based on the difference between the applicable Medicare rate and the fees underlying the current capitation rate, rather than the 2009 base rate, the amount eligible for 100% FFP may be more or less than the additional payment made to the health plans.

To determine the amount of managed care expenditure subject to the enhanced match rate, the Agency will compare the applicable Medicare fee to the 2009 base rate fee described in Section II of this document. That increase increment will be multiplied by the eligible utilization reported by the plans in their quarterly reports. All these calculations will be done at the procedure code level, by Medicare geographic area. Calculations will also be performed at the rate group and adult/child level, because the 2009 base varies significantly between dual eligible and Medicaid-only recipients, and between adults and children. See the attached example for an illustration of this calculation.

Example Calculations for 1) Payment Differentials Made to Health Plans and 2) Increment Eligible for 100% FMAP

All Numbers are Illustrative

Managed Care Program	Health Plan	Procedure Code	Procedure Description	Medicare Region	Medicaid Region	Provider Type	Month of Service	Dual Status	Age	# of Services *(A)*	2009 Base Fee *(B)*	Fee in Cap *(C)*	Medicare Fee *(D)*	Payment Differential *(D - C) * A*	Eligible for 100% FMAP *(D - B) * A*
Non-Reform	MCO A	99211	Office Visit, Est Patient, Level 1	Miami	11	Physician	Mar-13	Non-Dual	Adult	400	$12.00	$13.00	$23.00	$4,000	$4,400
Non-Reform	MCO A	99212	Office Visit, Est Patient, Level 2	Miami	11	Physician	Mar-13	Non-Dual	Adult	500	$20.00	$22.00	$50.00	$14,000	$15,000
Non-Reform	MCO A	99213	Office Visit, Est Patient, Level 3	Miami	11	Physician	Mar-13	Non-Dual	Adult	800	$25.00	$28.00	$80.00	$41,600	$44,000
Non-Reform	MCO A	99214	Office Visit, Est Patient, Level 4	Miami	11	Physician	Mar-13	Non-Dual	Adult	500	$40.00	$40.00	$120.00	$40,000	$40,000
Non-Reform	MCO A	99215	Office Visit, Est Patient, Level 5	Miami	11	Physician	Mar-13	Non-Dual	Adult	400	$60.00	$60.00	$165.00	$42,000	$42,000
Non-Reform	MCO A	99211	Office Visit, Est Patient, Level 1	Miami	11	Extender	Mar-13	Non-Dual	Adult	100	$9.60	$10.40	$18.40	$800	$880
Non-Reform	MCO A	99212	Office Visit, Est Patient, Level 2	Miami	11	Extender	Mar-13	Non-Dual	Adult	125	$16.00	$17.60	$40.00	$2,800	$3,000
Non-Reform	MCO A	99213	Office Visit, Est Patient, Level 3	Miami	11	Extender	Mar-13	Non-Dual	Adult	200	$20.00	$22.40	$64.00	$8,320	$8,800
Non-Reform	MCO A	99214	Office Visit, Est Patient, Level 4	Miami	11	Extender	Mar-13	Non-Dual	Adult	125	$32.00	$32.00	$96.00	$8,000	$8,000
Non-Reform	MCO A	99215	Office Visit, Est Patient, Level 5	Miami	11	Extender	Mar-13	Non-Dual	Adult	100	$48.00	$48.00	$132.00	$8,400	$8,400
Non-Reform	MCO A	99211	Office Visit, Est Patient, Level 1	Miami	11	Physician	Mar-13	Non-Dual	Child	3,200	$12.48	$13.52	$23.00	$30,336	$33,664
Non-Reform	MCO A	99212	Office Visit, Est Patient, Level 2	Miami	11	Physician	Mar-13	Non-Dual	Child	4,000	$20.80	$22.88	$50.00	$108,480	$116,800
Non-Reform	MCO A	99213	Office Visit, Est Patient, Level 3	Miami	11	Physician	Mar-13	Non-Dual	Child	6,400	$26.00	$29.12	$80.00	$325,632	$345,600
Non-Reform	MCO A	99214	Office Visit, Est Patient, Level 4	Miami	11	Physician	Mar-13	Non-Dual	Child	4,000	$41.60	$41.60	$120.00	$313,600	$313,600
Non-Reform	MCO A	99215	Office Visit, Est Patient, Level 5	Miami	11	Physician	Mar-13	Non-Dual	Child	3,200	$62.40	$62.40	$165.00	$328,320	$328,320
Non-Reform	MCO A	99211	Office Visit, Est Patient, Level 1	Miami	11	Extender	Mar-13	Non-Dual	Child	800	$9.98	$10.82	$18.40	$6,067	$6,733
Non-Reform	MCO A	99212	Office Visit, Est Patient, Level 2	Miami	11	Extender	Mar-13	Non-Dual	Child	1,000	$16.64	$18.30	$40.00	$21,696	$23,360
Non-Reform	MCO A	99213	Office Visit, Est Patient, Level 3	Miami	11	Extender	Mar-13	Non-Dual	Child	1,600	$20.80	$23.30	$64.00	$65,126	$69,120
Non-Reform	MCO A	99214	Office Visit, Est Patient, Level 4	Miami	11	Extender	Mar-13	Non-Dual	Child	1,000	$33.28	$33.28	$96.00	$62,720	$62,720
Non-Reform	MCO A	99215	Office Visit, Est Patient, Level 5	Miami	11	Extender	Mar-13	Non-Dual	Child	800	$49.92	$49.92	$132.00	$65,664	$65,664
Non-Reform	**MCO A**	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**	**TOTAL**	**29,250**				**$1,497,562**	**$1,540,061**

Notes:

1. Leftmost columns (through Column A) reflect the concept of the report that would be submitted quarterly by the health plans; the remaining columns reflect fees and calculations that would be established and populated by the Agency.
2. Column (A), Number of services provided, will be reported to the Agency by the health plans. This count will reflect only services provided by qualified providers, and will be supported by reference to specific encounter claims.
3. Column (B), 2009 Base Fee, will be populated with the State Medicaid fee applicable on July 1, 2009. See the accompanying narrative, which explains that the rate methodologies in effect during 2009 for all programs were designed to assume physician unit costs were equal to the Medicaid FFS fee schedule.
4. Column (C), Fee in Capitation Rate, will reflect the unit cost assumed in the capitation rate that applied on the date of service in the specified managed care program and Medicaid region. As described in the attached narrative, this value may not equal the Medicaid FFS fee schedule value.
5. Column (D), Medicare Fee, will reflect the applicable non-facility fee in effect in the specific Medicare region for the date of service, using the 2009 conversion factor or the current conversion factor, whichever is greater.

EXHIBIT "F"

From: Kaufman, Nicole L. (CMS/CMCS) [mailto:Nicole.Kaufman@cms.hhs.gov]
Sent: Monday, April 29, 2013 8:59 AM
To: Macdonald, Linda
Cc: Brimage, Cheryl L. (CMS/CMCHO); Roberts, Shantrina D. (CMS/CMCHO); Frix, Terry (CMS/CMCHO); Staton, Sidney H. (CMS/CMCHO); Reed, Steve M. (CMS/CMCHO); Davis, Lovie (CMS/CMCS)
Subject: CMS's Initial Feedback on Florida's Managed Care Methodology Submission

Good Morning,

Please find CMS's questions based on the initial review of Florida's managed care methodology submission.

1. Florida stated that they do not need to adjust D-SNP rates since they already pay providers at Medicare levels (page 2, footnote 1). However, because the adjusted Medicare rate (using the 2009 conversion factor) is higher than the 2013 Medicare rate, we would expect that the payments would likewise be higher in D-SNPs. As noted in section 4.3 of the Technical Guidance, the state does not need to claim 100% FFP on this differential for dual eligible cost sharing, but the increased payment would need to be made.

a. An example for the dual eligible calculation similar to what is provided on page 6 for non-duals would be helpful in verifying the proposed methodology for dual eligibles.

2. Florida stated that they do not plan to adjust long-term care plan rates (pages 2 and 3). Please confirm that the LTC plans do not cover any eligible primary care services.

3. PACE is excluded from the enhanced payments required under section 1202 of the ACA. Please confirm that Florida will not claim 100% FFP for primary care services rendered through PACE.

4. As Florida is beginning a new program (Managed Medical Assistance, or MMA) in 2014, the State proposes to use a methodology in that year similar to what they are submitting now and that the State would only resubmit a proposal if an alternative methodology is used (pages 2 and 3). CMS clarifies here that a new methodology submission for CY 2014 is required if the state changes the model used for making the enhanced payment to eligible providers or proposes a material change to how the 2009 baseline or rate differential calculations are made.

5. The State does not describe any steps it will take to ensure proper payment was passed on to providers. The State requires the plans to submit utilization and encounter data to calculate the payment each plan is due, but no information about what was actually paid. Please describe how Florida will verify that the payments were made to eligible providers.

6. Please describe the process for identifying eligible primary care providers. Is the Agency responsible for collecting the self-attestations from providers or will any part of this process be delegated to the contracted health plans?

7. On the top of page 5 the State notes that for current rates they "will identify the average primary care unit cost that underlies the capitation payments for each program and rate group." Please confirm this will be based on the same data used in the development of the capitation rates, with similar adjustments.

8. The methodology provides limited information regarding the Vaccine Administrative payments. Can the State provide any more information regarding how the calculation of the payment differential and 100% federal match will differ from the Evaluation & Management codes?

9. The methodology did not comment on how claims occurring at FQHCs or RHCs will be handled. Please confirm that enhanced payments to FQHCs and RHCs are not required and will not be included in the calculation of the 100% FFP match.

10. Please confirm any increases in non-claim expenses due to the increase payments will not be included in the calculation for the 100% FFP match.
We look forward to your responses.

Regards,
Nicole

Nicole Kaufman, J.D., LL.M
Acting Technical Director - Managed Care Operations
Division of Integrated Health Systems
Disabled & Elderly Health Programs Group
Center for Medicaid & CHIP Services, CMS
Mailstop S2-14-26, 7500 Security Blvd., Baltimore, MD 21244
P: (410) 786-6604
F: (410) 786-5882
Nicole.Kaufman@cms.hhs.gov<mailto:Nicole.Kaufman@cms.hhs.gov>

EXHIBIT "G"

From: Macdonald, Linda
Sent: Monday, June 24, 2013 5:41 PM
To: Kaufman, Nicole L. (CMS/CMCS); Brimage, Cheryl L. (CMS/CMCHO); Frix, Terry (CMS/CMCHO); Roberts, Shantrina D. (CMS/CMCHO); Staton, Sidney H. (CMS/CMCHO); Reed, Steve M. (CMS/CMCHO); Davis, Lovie (CMS/CMCS)
Cc: Lampkin, Stacey; Chang, Karen; Brown-Woofter, Melanie; Harris, Shevaun; Gill, Lisa
Subject: FL Responses: CMS's Initial Feedback on Florida's Managed Care Methodology Submission

Nicole,

The following are the Agency's responses to your questions regarding Florida's managed care methodology submission. Let us know if you need any additional information.

Thanks, Linda

Florida Responses:

Please find CMS's questions based on the initial review of Florida's managed care methodology submission.

1. Florida stated that they do not need to adjust D-SNP rates since they already pay providers at Medicare levels (page 2, footnote 1). However, because the adjusted Medicare rate (using the 2009 conversion factor) is higher than the 2013 Medicare rate, we would expect that the payments would likewise be higher in D-SNPs. As noted in section 4.3 of the Technical Guidance, the state does not need to claim 100% FFP on this differential for dual eligible cost sharing, but the increased payment would need to be made.

    a. An example for the dual eligible calculation similar to what is provided on page 6 for non-duals would be helpful in verifying the proposed methodology for dual eligibles.

    Agency Response: We have discussed your comment with our contracted actuary and agree that the higher 2009 conversion factor does suggest an increased payment is appropriate. Florida will work with our capitated D-SNP plans to operationalize this increase for their physicians.

    In general, for dual eligibles enrolled in other programs, we expect the methodology to work similar to the process for non-duals, except the schedule of unit costs implied in the capitation rates will look very different than it does for non-duals, as will the applicable Medicare rate. We are working with our contracted actuaries on validating the data to prepare the fee schedule, and will provide an example once realistic values are available.

2. Florida stated that they do not plan to adjust long-term care plan rates (pages 2 and 3). Please confirm that the LTC plans do not cover any eligible primary care services.

    Agency Response: The SMMC LTC plans that will begin enrollment later in 2013 do not cover primary care services. They cover only long term care supports and services, and thus the PCP fee increase will not apply to them. Our current LTC plans, Nursing Home Diversion and Frail Elder, do cover primary care services and are included in the

methodology document. These programs will sunset as the new SMMC LTC rolls out in a staged regional roll-out beginning August 1, 2013.

3. PACE is excluded from the enhanced payments required under section 1202 of the ACA. Please confirm that Florida will not claim 100% FFP for primary care services rendered through PACE.

   Agency Response: Florida will not claim 100% FFP for primary care services rendered through PACE. We will clarify the methodology document to confirm this point, if requested.

4. As Florida is beginning a new program (Managed Medical Assistance, or MMA) in 2014, the State proposes to use a methodology in that year similar to what they are submitting now and that the State would only resubmit a proposal if an alternative methodology is used (pages 2 and 3). CMS clarifies here that a new methodology submission for CY 2014 is required if the state changes the model used for making the enhanced payment to eligible providers or proposes a material change to how the 2009 baseline or rate differential calculations are made.

   Agency Response: Florida does not expect the methodology to require adjustment for the new program. However, if an adjustment is required, we will submit an updated methodology document for review and approval.

5. The State does not describe any steps it will take to ensure proper payment was passed on to providers. The State requires the plans to submit utilization and encounter data to calculate the payment each plan is due, but no information about what was actually paid. Please describe how Florida will verify that the payments were made to eligible providers.

Agency Response: Florida plans the following steps related to confirmation of payment.

   a. ***Plans will be required to provide physicians with an EOB or other detailed schedule of claims for which enhanced payment is being provided. The Agency will investigate any complaints from providers that appropriate payment is not being made.***

   b. ***Plans will be required to provide quarterly the check run or similar documentation of the enhanced payments made during the prior quarter. The Agency has worked with the plans to develop a format that can be readily produced by the plans. The resulting report shows specific providers, services, and payment dates.***

   c. ***Annually, the State will audit a sample of claims to trace the entire process through, from identification of provider eligibility for the increase, so payment amount determination, to actual payment made.***

6. Please describe the process for identifying eligible primary care providers. Is the Agency responsible for collecting the self-attestations from providers or will any part of this process be delegated to the contracted health plans?

***Agency Response:** The Agency will collect attestations for providers who are also enrolled as FFS Medicaid providers. For providers who are not enrolled as FFS Medicaid providers, plans are responsible for collecting attestations or confirming eligibility through credentialing materials, if appropriate. The Agency is working with the plans to determine the feasibility of maintaining a centralized data base of increase-eligible providers across the program.*

7. On the top of page 5 the State notes that for current rates they "will identify the average primary care unit cost that underlies the capitation payments for each program and rate group." Please confirm this will be based on the same data used in the development of the capitation rates, with similar adjustments.

***Agency Response:** For programs and rates set using historical FFS data, those same FFS data sets will be used to develop the average unit costs that underlie the capitation rates, adjusted using the appropriate unit cost adjustments from the rate setting methodology.*

Health plan physician experience from financial reports is blended with FFS data to develop the physician services component of most rate groups in the current Reform and Non-Reform MCO capitation rate development process. For the purpose of developing the imbedded fee schedule of increase eligible codes, the actuaries will use health plan encounter data from the same time periods of the rate base financials, and will blend and adjust those results with FFS data using the same weights and adjustments used in the rate setting process.

Currently, Nursing Home Diversion program rates are developed using summarized encounter data. The State does not have access to claim-level encounter data from those historical periods. Therefore, for this program, which enrolls solely dual-eligibles, the State and its actuaries have determined that the fee schedule developed for the dual eligible population enrolled in the Frail Elder program will represent an appropriate proxy fee schedule. Dual eligibles in the Frail Elder program are similar in age and risk profile to NHD enrollees.

8. The methodology provides limited information regarding the Vaccine Administrative payments. Can the State provide any more information regarding how the calculation of the payment differential and 100% federal match will differ from the Evaluation & Management codes?

***Agency Response:** Florida expects the vaccine payment increases to follow the same general approach described in the methodology document and using the specific parameters laid out in our approved State Plan Amendment. Florida Medicaid has historically used the vaccine product CPT codes to reimburse the vaccine administration fee for recipients ages 0-18 who are eligible for the VFC program. If a recipient is not eligible for the VFC program, the vaccine product CPT codes include both the cost of the vaccine and the regular Medicaid administration fee. The Agency has activated the vaccine administration codes to pay the difference between the regular Medicaid administration fee and the increased primary care administration fee. Since Medicaid reimburses the vaccine administration fees exclusively to*

physicians eligible for the enhanced fee, the vaccine administration fees equal the difference between the regular and enhanced rates.

For managed care implementation, our contracted actuaries will provide a fee schedule of the average unit costs in the capitation rates for the vaccine product CPT codes, segmented by children and adults. The difference between those fees and the appropriate higher fee will be paid to the plans. Plans will pay the increases to the physicians based on submission of the appropriate vaccine administration code.

9. The methodology did not comment on how claims occurring at FQHCs or RHCs will be handled. Please confirm that enhanced payments to FQHCs and RHCs are not required and will not be included in the calculation of the 100% FFP match.

Agency Response: Enhanced payments to FQHCs and RHCs are not required and will not be included in the calculation of the 100% FFP match. Please see attached policy transmittal that was provided to the health plans and specifically excludes FQHCs, RHCs, and other clinics paid on an encounter basis.

10. Please confirm any increases in non-claim expenses due to the increase payments will not be included in the calculation for the 100% FFP match.

Agency Response: Increases in non-claim expenses due to the increased payments will not be included in the calculation for the 100% FFP match. Florida will include such assurance language in an updated methodology document, if requested.

Linda Macdonald
Senior Management Analyst II
Agency for Health Care Administration
Medicaid Bureau of Medicaid Services
2727 Mahan Drive, Bldg 3, MS 50
Tallahassee, Florida 32308
Phone: (850) 412-4031
E-mail: mailto:Linda.Macdonald@ahca.myflorida.com"> Linda.Macdonald@ahca.myflorida.com

http://ahca.myflorida.com/Executive/Inspector_General/complaints.shtml">

cid:image001.png@01CE70FE.7E3A5800" alt="4760 REPORT MEDICAID FRAUD Web Button">

From: Kaufman, Nicole L. (CMS/CMCS)
[mailto:Nicole.Kaufman@cms.hhs.gov">mailto:Nicole.Kaufman@cms.hhs.gov]
Sent: Monday, April 29, 2013 8:59 AM
To: Macdonald, Linda
Cc: Brimage, Cheryl L. (CMS/CMCHO); Roberts, Shantrina D. (CMS/CMCHO); Frix, Terry (CMS/CMCHO); Staton, Sidney H. (CMS/CMCHO); Reed, Steve M. (CMS/CMCHO); Davis, Lovie (CMS/CMCS)
Subject: CMS's Initial Feedback on Florida's Managed Care Methodology Submission

Good Morning,

Please find CMS's questions based on the initial review of Florida's managed care methodology submission.

1. Florida stated that they do not need to adjust D-SNP rates since they already pay providers at Medicare levels (page 2, footnote 1). However, because the adjusted Medicare rate (using the 2009 conversion factor) is higher than the 2013 Medicare rate, we would expect that the payments would likewise be higher in D-SNPs. As noted in section 4.3 of the Technical Guidance, the state does not need to claim 100% FFP on this differential for dual eligible cost sharing, but the increased payment would need to be made.
    a. An example for the dual eligible calculation similar to what is provided on page 6 for non-duals would be helpful in verifying the proposed methodology for dual eligibles.
2. Florida stated that they do not plan to adjust long-term care plan rates (pages 2 and 3). Please confirm that the LTC plans do not cover any eligible primary care services.
3. PACE is excluded from the enhanced payments required under section 1202 of the ACA. Please confirm that Florida will not claim 100% FFP for primary care services rendered through PACE.
4. As Florida is beginning a new program (Managed Medical Assistance, or MMA) in 2014, the State proposes to use a methodology in that year similar to what they are submitting now and that the State would only resubmit a proposal if an alternative methodology is used (pages 2 and 3). CMS clarifies here that a new methodology submission for CY 2014 is required if the state changes the model used for making the enhanced payment to eligible providers or proposes a material change to how the 2009 baseline or rate differential calculations are made.
5. The State does not describe any steps it will take to ensure proper payment was passed on to providers. The State requires the plans to submit utilization and encounter data to calculate the payment each plan is due, but no information about what was actually paid. Please describe how Florida will verify that the payments were made to eligible providers.
6. Please describe the process for identifying eligible primary care providers. Is the Agency responsible for collecting the self-attestations from providers or will any part of this process be delegated to the contracted health plans?
7. On the top of page 5 the State notes that for current rates they "will identify the average primary care unit cost that underlies the capitation payments for each program and rate group." Please confirm this will be based on the same data used in the development of the capitation rates, with similar adjustments.

8. The methodology provides limited information regarding the Vaccine Administrative payments. Can the State provide any more information regarding how the calculation of the payment differential and 100% federal match will differ from the Evaluation & Management codes?
9. The methodology did not comment on how claims occurring at FQHCs or RHCs will be handled. Please confirm that enhanced payments to FQHCs and RHCs are not required and will not be included in the calculation of the 100% FFP match.
10. Please confirm any increases in non-claim expenses due to the increase payments will not be included in the calculation for the 100% FFP match.

We look forward to your responses.

Regards,
Nicole

Nicole Kaufman, J.D., LL.M
Acting Technical Director – Managed Care Operations
Division of Integrated Health Systems
Disabled & Elderly Health Programs Group
Center for Medicaid & CHIP Services, CMS
Mailstop S2-14-26, 7500 Security Blvd., Baltimore, MD 21244
P: (410) 786-6604
F: (410) 786-5882
mailto:Nicole.Kaufman@cms.hhs.gov">Nicole.Kaufman@cms.hhs.gov

EXHIBIT "H"

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

June 14, 2013

Justin Senior
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Senior:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your request to amend Florida's section 1115 Demonstration project, retitled Managed Medical Assistance Program (MMA) from Medicaid Reform (Project Number 11-W-00206/4). This amendment allows the state to implement a new model of managed care to all counties in Florida subject to approval of an implementation plan and a determination of readiness based on the elements of that plan. It also retains improvements to the demonstration that were added in the December 2011 renewal, including enhanced managed care requirements, a Medical Loss Ratio (MLR) requirement of 85 percent and the continuation of the Low Income Pool (LIP) of $1 billion (total computable) annually.

In order to assure readiness, the state shall implement the MMA program on a staggered region-by-region basis, no sooner than January 1, 2014. The state must assess plan readiness in each region, including capacity, access to care outside of the network, access to care for enrollees with special health care needs and cultural considerations. Mandatory enrollment in any region cannot proceed until CMS has approved the implementation plan, which will include identified risks, mitigation strategies, and fail safes that must be met before any region "goes live."

As noted in our February 2013 letter, priorities for CMS in considering this amendment request included the development of enhanced stakeholder engagement strategies, strengthened beneficiary protections, a comprehensive quality improvement strategy, and new provisions relating to monitoring, evaluation and transparency. To that end, with agreement by the state, the terms and conditions for this amendment include new stakeholder engagement processes and consumer protections to ensure beneficiary education, assistance and continuity of care. In addition, the state will develop a comprehensive quality strategy that reflects the health needs of Florida beneficiaries across the state's Medicaid program at large, that has specific data-driven achievable goals and strategies, and that is aligned with the broader goals of improving care, and lowering cost through care improvements. All participating health plans will be required to perform Performance Improvement Projects (PIPs). The terms and conditions and the state's

associated invitation (to plans) to negotiate also include enhancements regarding data collection, monitoring and evaluation.

CMS approval of this section 1115 demonstration amendment is subject to the limitations specified in the approved waiver and expenditure authorities and the list of requirements that are not applicable to the expenditure authorities. The state may deviate from the Medicaid State plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to the expenditure authorities. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable shall apply to Florida's Managed Medical Assistance program. This approval is also conditioned upon continued compliance with the enclosed special terms and conditions (STCs) defining the nature, character, and extent of federal involvement in this project.

These approvals are conditioned upon written acceptance from the state that it agrees with the amendments, expenditure authorities, and STCs. This written acceptance is needed for our records within 30 days of the date of this letter.

If you have any questions about this approval, please contact Jennifer Ryan, Acting Director for the Children and Adults Health Programs Group at CMS. Your project officer is Ms. Heather Hostetler. Ms. Hostetler's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard
Mail Stop S2-02-26
Baltimore, MD 21244-1850
Telephone: (410) 786-4515
Facsimile: (410) 786-8534
E-mail: Heather.Hostetler@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Hostetler and to Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's address is:

Jackie Glaze
Centers for Medicare & Medicaid Services
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909
Telephone: (404) 562-7417
E-mail: Jackie.Glaze@cms.hhs.gov

Thank you for your and your staff's thoughtful work on this demonstration amendment. We look forward to a successful implementation.

Sincerely,

Cindy Mann
Director

Enclosures

cc: Jennifer Ryan, CMCS
Jackie Glaze, Associate Regional Administrator, Region IV
Heather Hostetler, CMCS

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Managed Medical Assistance Program**

AWARDEE: **Agency for Health Care Administration**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Florida Managed Medical Assistance Program section 1115(a) demonstration (hereinafter "demonstration"). The parties to this agreement are the Agency for Health Care Administration (Florida) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The effective date of the demonstration is December 16, 2011, and is approved through June 30, 2014.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Florida Medicaid Reform demonstration was approved October 19, 2005. The state implemented the demonstration July 1, 2006, in Broward and Duval Counties, and then expanded to Baker, Clay, and Nassau Counties July 1, 2007. On December 15, 2011, CMS agreed to extend the demonstration through June 30, 2014.

The December 2011 renewal included several important improvements to the demonstration, such as; enhanced managed care requirements to ensure increased stability among managed care plans, minimize plan turnover, and provide for an improved transition and continuity of care when enrollees change plans and to ensure adequate choice of providers. The renewal also included a Medical Loss Ratio (MLR) requirement of 85 percent for Medicaid operations. Finally, the renewal included the continuation of the Low Income Pool (LIP) of $1 billion (total computable) annually to assist safety net providers in providing health care services to Medicaid, underinsured and uninsured populations.

On June 14, 2013, CMS approved an amendment to the demonstration which retains all of the improvements noted above, but allows the state to extend an improved model of managed care to all counties in Florida subject to approval of an implementation plan and a determination of readiness based on the elements of the approved plan. The amendment also changes the name of the demonstration to the Florida Managed Medical Assistance (MMA) program. Beginning no earlier than January 1, 2014, the MMA program implementation will begin. The Medicaid Reform demonstration will remain in effect in the five Medicaid Reform counties until the MMA program is implemented.

Under the amended demonstration, most Medicaid eligibles are required to enroll in a managed care plan (either a capitated managed care plan or a fee-for-service (FFS) Provider Service Network (PSN) as a condition for receiving Medicaid. Participation is mandatory for TANF related populations and the aged and disabled with some exceptions. The demonstration continues to allow plans to offer customized benefit packages and reduced cost-sharing, although each plan must cover all mandatory services, and all state plan services for children and pregnant women (including EPSDT). The demonstration provides incentives for healthy behaviors by offering Enhanced Benefits Accounts that will be replaced by the plan's Healthy Behaviors program upon implementation of the MMA program as described in paragraph 65. Beneficiaries in counties transitioning from Medicaid Reform to MMA will continue to have access to their accrued credits under EBAP for one year.

The amended terms and conditions include improvements such as:

- A phased implementation to ensure readiness including a readiness assessment for each region and a requirement for CMS approval of the state's implementation plan which will include identified risks, mitigation strategies, and fail safes, stakeholder engagement and rapid cycle improvement strategies;
- Strengthened auto-enrollment criteria to ensure consideration of network capacity, access, continuity of care, and preservation of existing patient-provider relationships when enrolling all beneficiaries into the MMA program, including special populations;

- STCs tailored to special populations, should the state choose to include specialty plans in the final selection of managed care entities and PSNs;
- Strong consumer protections to ensure beneficiary assistance and continuity of care through the MMA transition. Additional STCs to ensure beneficiary choice, including a comprehensive outreach plan to educate and communicate with beneficiaries, providers, and stakeholders and annual Health Plan Report Cards for consumers, which will allow beneficiaries to be more informed on health plan performance and assist beneficiaries in making informed decisions related to plan selection;
- Enhanced Medical Care Advisory Committee (MCAC) requirements to ensure beneficiary and advocate group participation as well as inclusion of sub-population advisory committees;
- Performance Improvement Projects (PIPs) to be performed by all health plans;
- Clarification and enhancements of the monitoring and evaluation of plans to ensure a rigorous and independent evaluation, and development of rapid cycle, transparent monitoring in order to ensure continuous progress towards quality improvement; and,
- A Comprehensive Quality Strategy (CQS) that will span the entire Florida Medicaid program.

Under the demonstration, Florida seeks to continue building on the following objectives:

- Introduce more individual choice, increase access, and improve quality and efficiency while stabilizing cost;
- 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;
- Improve health outcomes and reduce inappropriate utilization;
- Demonstrate that by moving most recipients into a coordinated care-managed environment, the overall health of Florida's most vulnerable citizens will improve;
- Serve as an effective deterrent against fraud and abuse by moving from a fee-for-service to a managed care delivery system;
- Maintain strict oversight of managed care plans including adapting fraud efforts to surveillance of fraud and abuse within the managed care system;
- Provide managed care plans with flexibility in creating benefit packages to meet the needs of specific groups; and,
- Provide plans the ability to substitute services and cover services that would otherwise not be covered by traditional Medicaid.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid Program expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents, of which these terms and conditions are part, must apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy.**

   a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b) If mandated changes in the federal law, regulation, or policy requires state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit a Title XIX state plan amendment for changes to any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan is required, except as otherwise noted in these STCs.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to program design, eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, LIP, federal financial participation (FFP), sources of non-federal share of funding, budget neutrality, and other comparable program and budget elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7, below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the

change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with the STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must be accompanied by information that includes but is not limited to the following:

a) An explanation of the public process used by the state, consistent with the requirements of paragraph 16, to reach a decision regarding the requested amendment;

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

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

d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Enhanced Benefits Account Program Phase Out.** The state shall submit a phase-out plan to CMS for approval no later than 6 months prior to any such time the state proposes to terminate the Enhanced Benefits Account Program (EBAP) provision of this demonstration. The EBAP will be limited as follows:

a) Enrollees will not be able to earn credits for enhanced benefits for deposit into their account during the last 3 months of the demonstration or the termination of the EBAP Provision under the demonstration; and

b) Individuals, who previously earned credits for enhanced benefits in their account, will continue to have access to funds for health care related expenditures in accordance with EBAP rules (see paragraph 61).

9. **Extension of the Demonstration.**

a) States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 10.

b) As part of the demonstration extension request, the state must provide documentation of compliance with the transparency requirements in 42 CFR § 431.412 and the public notice requirements outlined in paragraph 16, as well as include the following supporting documentation:

i. Historical Narrative Summary of the Demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The state must provide summaries of External Quality Review Organization (EQRO) reports, health plan state quality assurance monitoring, and any other documentation of the quality of care provided or corrective action taken under the demonstration.

v. Financial Data: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If Title XXI funding is used in the demonstration, a CHIP allotment neutrality worksheet must be included.

vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Documentation of Public Notice 42 CFR § 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described

in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

10. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

    a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

    The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

    b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

    c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

    d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

11. **Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

    a) Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

    b) Expiration Procedures: The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

    c) Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

    d) Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

13. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

14. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or

expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

15. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

16. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must continue to comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) unless they are otherwise superseded by rules promulgated by CMS. The state must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and/or renewal of this demonstration.

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

    The state must maintain:

    a) Policies to ensure an increased stability among capitated managed care plans and FFS PSNs and minimize plan turnover. This could include a limit on the number of participating plans in the five Medicaid Reform demonstration counties and, when implemented, in the MMA program. Plan selection and oversight criteria should include: confirmation that solvency requirements are being met; an evaluation of prior business operations in the state; and financial penalties for not completing a contract term. The state must report quarterly on the plans entering and leaving demonstration counties, including the reasons for plans leaving. The state must provide these policies to CMS within 90 days of the award of the MMA program demonstration amendment.

    b) Requirements contained herein are intended to be consistent with and not additional to the requirements of 42 CFR 438. Policies to ensure network adequacy and access requirements which address travel time and distance, as well as the availability of

routine, urgent and emergent appointments, and which are appropriate for the enrolled population. Policies must include documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The state must implement a thorough and consistent oversight review for determining plan compliance with these requirements and report these findings to CMS on a quarterly basis. The state must provide these policies to CMS within 90 days of the award of the MMA program demonstration amendment.

c) A requirement that each capitated managed care plan and capitated PSN maintain an annual Medical Loss Ratio (MLR) of 85 percent for Medicaid operations in the demonstration counties. These entities must provide documentation to the state and CMS at least annually to show ongoing compliance. The state must develop quarterly reporting of MLR during demonstration year (DY) 6 specific to demonstration counties. Beginning in DY 7 (July 1, 2012), plans must meet annual MLR requirements. MLR requirements are to be reported by the capitated plans 7 months after the quarter ends to allow for the claims run-out period. CMS will determine the corrective action for non-compliance with this requirement.

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

e) Policies to ensure adequate choice of providers when there are fewer than two plans in any rural county, including contracting on a regional basis where appropriate to assure access to physicians, facilities, and services.

f) Policies that result in a network of appropriate dental providers sufficient to provide adequate access to all covered dental services, in accordance with 42 CFR 428.206.

18. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 90, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 91.

IV. ELIGIBILITY FOR MEDICAID REFORM AND THE MANAGED MEDICAL ASSISTANCE PROGRAM

19. **Consistency with State Plan Eligibility Criteria.** There is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan. There is no eligibility expansion or reduction under this demonstration except that individuals who lose Medicaid eligibility will continue for a period of one-year to have access to benefits accrued in their name under the EBAP. See section XII.

20. **Participation in Medicaid Reform.** The following eligibility requirements remain in effect for Reform counties until such time that the MMA program is established in the Reform counties. Note: the MMA program must not be implemented earlier than January 1, 2014. Reform Participants are individuals eligible under the approved state plan who reside in Reform Counties who are described below as "mandatory participants" or as "voluntary participants". Mandatory participants are required to enroll in a capitated managed care plan or FFS PSN as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a demonstration capitated managed care plan or FFS PSN to receive Medicaid benefits.

a) Mandatory Participants - Individuals who reside in Reform Counties and who belong to the categories of Medicaid eligibles listed in the following table and who are not listed as excluded from mandatory participation are required to be Reform Participants.

Mandatory State Plan Groups	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Demonstration Population (See STC 94)**
Infants under age 1	Up to 150 % of the Federal Poverty Level (FPL)	Population 7
Children 1-5	Up to 133% of the FPL	Population 7
Children 6-18	Up to 100% of the FPL	Population 7
Blind/Disabled Children	Children eligible under SSI	Population 1
TANF Pregnant women	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.)	Population 7
Section 1931 adults	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.	Population 7
Aged/Disabled Adults	Persons receiving SSI whose eligibility is determined by SSA	Population 1
Optional State Plan Groups		
Infants under age 1 (Title XIX funded)	151% up to 185% of the FPL	Population 7

b) Voluntary Participants – The following individuals are excluded from mandatory participation under subparagraph (a) but may choose to be voluntary participants in the Reform demonstration:

i. Foster care children;

ii. Individuals with developmental disabilities not residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID);

iii. Individuals receiving hospice services;

iv. Pregnant women with incomes above the 1931 poverty level;

v. Medicare-Medicaid eligible individuals;

vi. Children under age 1 with family income 186% - 200% of the FPL under Title XXI; and,

vii. Children under age 18 eligible for adoption assistance.

c) Excluded from Reform Participation - The following groups of Medicaid eligibles are excluded from participation in the demonstration.

i. Individuals whose immigration status is as a refugee eligible;

ii. Individuals eligible as medically needy;

iii. Individuals residing in state mental facilities (age 21 and over);

iv. Family planning waiver eligibles;

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

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

21. **Participation in the MMA program**. The following describes the MMA program participation. Note: the MMA program must not be implemented earlier than January 1, 2014. MMA program participants are individuals eligible under the approved state plan, who reside in the MMA program regions and who are described below as "mandatory participants" or as "voluntary participants". Mandatory participants are required to enroll in a capitated managed care plan or FFS PSN as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a demonstration capitated managed care plan or FFS PSN to receive Medicaid benefits.

a) Mandatory Participants - Individuals who reside in one of the eleven regions where the MMA program has been implemented, who belong to the categories of Medicaid eligibles listed in the following table, and who are not listed as excluded from mandatory participation are required to be MMA program participants.

Mandatory State Plan Groups	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Demonstration Population (See STC 94)**
Infants under age 1	Up to 150% of the Federal Poverty Level (FPL)	Population 7
Children under age 1	With family income 186% - 200% of the FPL under Title XXI	Population 7
Children 1-5	Up to 133% of the FPL	Population 7
Children 6-18	Up to 100% of the FPL	Population 7
Blind/Disabled Children	Children eligible under SSI	Population 1
Foster Care	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL - Title IV-E)	Population 7
TANF Pregnant women	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.	Population 7
Pregnant women with incomes above the 1931 poverty level	Income greater than 1931 income level and not exceeding 150% of FPL.	Population 7
Section 1931 adults	Up to AFDC Income Level (Families whose income is below the TANF limit – 20% of the FPL or $303 per month for a family of 3, with assets less than $2,000.)	Population 7
Aged/Disabled Adults	Persons receiving SSI whose eligibility is determined by SSA	Population 1
Optional State Plan Groups		
Infants under age 1 (Title XIX funded)	151% up to 200% of the FPL	Population 7
Adoption assistance under age 18	Who receive an adoption subsidy	Population 7
Pregnant women with incomes above the 1931 poverty level	Income greater than 150% of Federal Poverty Level (FPL) and not exceeding 185% of FPL.	Population 7
Individuals eligible under a hospice-related eligibility group	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.	Population 1

b) Medicare-Medicaid Eligible Participants- Individuals fully eligible for both Medicare and Medicaid will be required to participate in the MMA program for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals' Medicare benefits. Medicare-Medicaid beneficiaries will be afforded the opportunity to choose an MMA plan. However, to facilitate enrollment, if the individual does not elect an MMA plan, then

the individual will be assigned to an MMA plan by the state using the criteria outlined in STC 23.

c) Voluntary Participants – The following individuals are excluded from mandatory participation under subparagraph (a) but may choose to be voluntary participants in MMAP:

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

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

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

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

d) Excluded From MMA Program Participation - The following groups of Medicaid eligibles are excluded from participation in the demonstration.

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

ii. Family planning waiver eligibles;

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

iv. Children receiving services in a prescribed pediatric extended care facility.

Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law, are not eligible for FFP.

V. ENROLLMENT

This section describes enrollment provisions that are applicable to Medicaid eligible individuals living in Florida counties in which either Medicaid Reform or the MMA program demonstration has been implemented.

22. **New Enrollees.** At the time of eligibility determination, individuals who are mandated to participate must receive information about managed care plan choices in their area. They must be informed of their options in selecting an authorized managed care plan. Individuals must be provided the opportunity to meet or speak with a choice counselor to obtain additional information in making a choice. New enrollees will be required to select a plan within 30 days of eligibility determination. If the individual does not select

a plan within the 30-day period, the state may auto-assign the individual into a capitated managed care plan or a FFS PSN in the Reform Counties or the MMA program when implemented. 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. Once the plan selection is registered and takes effect, the plan must communicate to the enrollee, in accordance with 42 CFR 438.10, the benefits covered under the plan, including dental benefits, and how to access those benefits.

23. **Auto-Enrollment Criteria.** Each enrollee must be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the choice counselor must provide information to the individuals to encourage an active selection. Enrollees who fail to choose within this timeframe will be auto-assigned to a managed care plan. At a minimum, the state must use the criteria listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the state will make enrollee assignments consecutively by family unit. The criteria include but are not limited to:

    a) A managed care plan has sufficient provider network capacity, including dental network capacity, to meet the needs of enrollees;

    b) 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;

    c) The state has knowledge that the enrollee has previously expressed a preference for a particular managed care plan as indicated by Medicaid FFS claims data, but has failed to make a choice; and,

    d) The managed care plan's primary care providers are geographically accessible to the recipient's residence.

24. **Auto Enrollment for Special Populations.** For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI beneficiary to a managed care plan, the state must determine whether the SSI beneficiary has an ongoing relationship with a provider or managed care plan; and if so, the state must assign the SSI recipient to that managed care plan whenever feasible. Those SSI recipients who do not have such a provider relationship must be assigned to a managed care plan using the assignment criteria previously outlined.

    In addition, the state must use the following parameters when assigning a recipient to a plan.

    a) To promote alignment between Medicaid and Medicare, each beneficiary who is enrolled with a Medicare Advantage Organization, must first be assigned to any MMA plan in the beneficiary's region that is operated by the same parent organization as the beneficiary's Medicare Advantage Organization. If there is no

match of parent organization or appropriate plan within the organization, then the beneficiary should be assigned as in paragraphs (a)-(d) above.

b) If an applicable specialty plan is available, the recipient should be assigned to the specialty plan.

c) If, in the first year of the first contract term only, a recipient was previously enrolled in a plan that is still available in the region, the recipient should be assigned to that plan.

d) Newborns of eligible mothers enrolled in a plan at the time of the child's birth will be automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 90 days after the child's birth.

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

25. **Lock-In/Disenrollment**. Once a mandatory enrollee has selected or been assigned a Medicaid Reform plan or MMA plan, the enrollee shall be enrolled in the plan for a total of 12 months, which includes a 90-day disenrollment period. Once an individual is enrolled into a plan the individual must have 90 days to voluntarily disenroll from that plan without cause and select another plan. If an individual chooses to remain in the plan past 90 days the individual will remain in the selected plan for an additional nine months for a total enrollment 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 treating 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 plan at any time.

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

26. **Re-enrollment.** In instances of a temporary loss of Medicaid eligibility, which the state is defining as 6 months or less, the state will re-enroll demonstration enrollees in the same capitated managed care plan or FFS PSN they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended.

VI. BENEFIT PACKAGES and PLANS in MEDICAID REFORM AND MMA PROGRAM

27. **Customized Benefit Packages**. Capitated managed care plans will have the flexibility to provide customized benefit packages for demonstration enrollees as long as the benefit package meets certain minimum standards described in this STC, and actuarial benefit equivalency requirements and benefit sufficiency requirements described in STCs 28-32. PSNs operating under FFS must provide all benefits for all enrolled beneficiaries as are available under the state plan. The customized benefit packages must include all state plan services otherwise available under the state plan for pregnant women and children including all EPSDT services for children under age 21. The customized benefit packages must include all mandatory services specified in the state plan for all populations. The amount, duration and scope of optional services, may vary to reflect the needs of the plan's target population and plans can offer additional services and benefits not available under the state plan. The plans contracted with the state shall not have service limits more restrictive than authorized in the state plan for children under the age of 21, pregnant women, and emergency services. The state may also capitate all state plan services for demonstration enrollees.

    Policies for determining medical necessity for children covered under the EPSDT benefit must be consistent with Federal statute at §1905(r) of the Social Security Act (the Act) in authorizing vision, dental, and hearing services, and other necessary health care, diagnostic services, treatment and other measures described in §1905(a) of the Act to correct or ameliorate defects and physical and mental illnesses and conditions discovered by screening services, whether or not such services are covered in the State plan.

28. **Overall Standards for Customized Benefit Packages.** 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 the plan's customized benefit package must meet a sufficiency test to ensure that it is sufficient to meet the medical needs of the target population.

29. **Plan Evaluation Tool.** The state will utilize a Plan Evaluation Tool (PET) to determine if a plan that is applying for a Medicaid Reform Plan contract or has been awarded an MMA plan contract meets state requirements. The PET measures for actuarial equivalency and sufficiency. Specifically, it 1) compares the value of the level of benefits (actuarial equivalency) in the proposed package to the value of the current state plan package for the average member of the population and 2) ensures that the overall level (sufficiency) of certain benefits is adequate to cover the vast majority of enrollees. The state will evaluate service utilization on an annual basis and use this information to update the PET to ensure that actuarial equivalence calculations and sufficiency thresholds reflect current utilization levels.

30. **Plan Evaluation Tool: Actuarial Equivalency.** Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid state plan services. This process ensures that the expected claim cost levels of all managed care plans are equal (using a common benchmark reimbursement structure) to the level of the historic FFS plan for the target

population and its historic levels of utilization. The state uses this as the first threshold to evaluate the customized benefit package submitted by a plan to ensure that the package earns the premium established by the state. In assessing actuarial equivalency, the PET considers the following components of the benefit package: services covered; cost sharing; and additional benefits offered, if any. Additional services offered by the plan will be considered a component of the plan's customized benefits and not a component of the Enhanced Benefit Plan.

31. **Plan Evaluation Tool: Sufficiency**. In addition to meeting the actuarial equivalence test, each health plan's proposed customized benefit package must meet or exceed, and maintain, a minimum threshold of 98.5 percent for benefits identified as sufficiency tested benefits. The sufficiency test provides a safeguard when plans elect to vary the amount, duration and scope of certain services. This standard is based on the target population's historic use of the applicable Medicaid state plan services (e.g. outpatient hospital services, outpatient pharmacy prescriptions) identified by the state as sufficiency tested benefits. Each proposed benefit plan must be evaluated against the sufficiency standard to ensure that the proposed benefits are adequate to cover the vast majority of enrollees. The sufficiency standard for a service may be based on the proportion of the historical utilization for the target population that is expected to exceed the plan's proposed benefit level.

32. **Evaluation of Plan Benefits.** The state will review and update the PET for assessing a plan's benefit structure to ensure actuarial equivalence and that services are sufficient to meet the needs of enrollees in the demonstration area. At a minimum, the state must conduct the review and update on an annual basis. The state will provide CMS with 60-days advance notice and a copy of any proposed changes to the PET.

VII. COST SHARING

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

VIII. FLORIDA MANAGED MEDICAID ASSISTANCE (MMA) PROGRAM IMPLEMENTATION

34. **Reform Implementation.** Counties where Reform was implemented in 2006 and 2007 are known as Reform Counties (Baker, Broward, Clay, Duval, and Nassau). No earlier than January 1, 2014, these counties will become MMA program counties when the MMA program is implemented in their respective region. Transition from Medicaid Reform counties to the MMA regions will follow implementation requirements as outlined in STCs 35 and 36.

35. **MMA Program Implementation Requirements.** No earlier than January 1, 2014, the state may implement the MMA program in a region if it meets the following implementation requirements for that region (subject to CMS review and approval).

Implementation Schedule: The state must submit to CMS a schedule indicating its planned start date for mandatory enrollment in the MMA program in each region of the state. The state may not begin mandatory enrollment in any region until CMS has approved the implementation plan. After CMS' approval of the implementation plan, the state may stagger mandatory enrollment over period beginning no earlier than January 1, 2014. The state will submit an implementation schedule to CMS by October 31, 2013, that specifies the regions to be transitioned in that timeframe with a staggered implementation approach. The state may revise the implementation schedule as needed, and must promptly notify CMS of any changes. The approved implementation plan will become a future attachment to these STCs.

a) The plan must include:

i. Identification of triggers that would prevent the state from proceeding with the next regional area for implementation;

ii. Identification of risks with the implementation;

iii. A mitigation strategy for the identified risks;

iv. A fail-safe or back-up plan in the event that the mitigation strategy fails;

v. Identification of circumstances that would stop the state proceeding with the implementation of the next region;

vi. The role of stakeholder feedback in determining further implementation of the next region; and

vii. A detailed description of the rapid cycle improvement process and electronic tracking system.

The state is required to submit an amendment no later than October 31, 2013 to Florida's Section 1915(b) Medicaid Managed Care Waiver, control # FL-01.R08, to reflect the phase out of that waiver.

b) **Transition plan.** The state must conduct an assessment of the plan transition needs for each region and will explain its policies to promote beneficiary continuity and continuation of care, particularly for beneficiaries who will no longer have access to his or her physician and beneficiaries who are enrolled in a managed care plan for their managed long term services and supports.

c) **Notice information.** The state must provide notice of the change in program authority and open enrollment to individuals in each region in simple and

understandable terms and in a manner that is accessible to persons who are limited English proficient and individuals living with disabilities.

d) **Readiness review.** The state must assess plan readiness in each region in accordance with the requirements of 42 CFR 438. Readiness reviews will include, but are not limited to, documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The state will also notify CMS of its intent to conduct a readiness review 30 days in advance of the review and provide CMS the opportunity to observe the readiness review. The state will provide CMS a copy of their readiness review feedback/corrective action plan letter and approval letters for each readiness review.

e) **Solvency assessment.** In accordance with STC 17, Managed Care Requirements, the state must evaluate the prior business operations of all health plans that apply to operate in the region, and confirm that they meet solvency standards. The state's managed care contract must include penalties for plans that do not complete the contract term.

f) **Compliance with Managed Care requirements**. The state must assure that all managed care plans in the region comply with all of the managed care requirements described in paragraph 17 of these special terms and conditions and EPSDT requirements described in paragraph 27 of these STCs.

g) Prior to implementation in each region, the state must submit a report to CMS on its compliance with subparagraphs (b) through (f) above, along with the most recent version of the implementation schedule mentioned in (a). The state may not initiate mandatory MMA program enrollment in a region unless CMS has received this report at least 30 days in advance of the implementation date for each region(s).

36. **MMA Program Regions.** The MMA program shall be implemented over a period beginning no earlier than January 1, 2014 and no later than October 1, 2014, as described in paragraph 35. The MMA program implementation regions are defined as follows:

Region	Counties
Region 1:	Escambia, Okaloosa, Santa Rosa and Walton
Region 2:	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3:	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
Region 4:	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5:	Pasco and Pinellas

Region 6:	Hardee, Highlands, Hillsborough, Manatee and Polk
Region 7:	Brevard, Orange, Osceola and Seminole
Region 8:	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9:	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
Region 10:	Broward
Region 11:	Miami-Dade and Monroe

IX. DELIVERY SYSTEMS

37. **Health Plans.** Health plans authorized under this demonstration must be authorized by state statute and must adhere to 42 CFR 438. Contracts with these entities may be risk or non-risk contract types. Capitation rates shall be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The certification shall identify historical utilization of state plan services used in the rate development process. The final contracts developed to implement selective contracting by the state with any managed care organization, provider group, Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) shall be subject to CMS Regional Office approval prior to implementation.

    a) Capitated Managed Care Organization – An entity (such as Health Maintenance Organization, Accountable Care Organization, capitated Provider Service Network, or Exclusive Provider Organization) that meets the definition of managed care organization (MCO) as described in 42 CFR 438.2, and which must conform to all of the requirements in 42 CFR 438 that apply to MCOs.

    b) Provider Service Network (PSN) – An entity established or organized by a health care provider or group of affiliated health care providers that meet the requirements of Florida Statutes. A PSN may be reimbursed on a FFS or capitated basis as specified in state statute. Capitated PSNs are categorized as MCOs, and must meet the requirements as described in 42 CFR 438.

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

38. **Number of Plans per Region.** The state will procure a specified number of plans per region for the MMA program. A minimum and maximum number of plans are specified by region, with a minimum of two plans choices in each of the 11 regions. Of the total contracts awarded per region, at least one award shall be a PSN if any PSNs submit a responsive bid. Issuance and award of the procurements will provide for a choice of plans, as well as market stability.

    Should the state not be able contract with at least two plans in a region that is not rural, the state will issue another procurement to obtain a second plan and meet the federal requirements in 438.52. Until two plans are available in the impacted region,

beneficiaries may voluntarily choose to enroll in the available managed care plan or to access services through a FFS delivery system.

In addition to regional plans, the state will also seek to contract with specialty plans, as discussed in STC 40. Participation of specialty plans will be subject to competitive procurement requirements but will not be considered in assessing regional plan availability. However, the state may not enter into contracts with specialty plans to the extent that the target populations include more than 10 percent of the enrollees of any one region.

Once the state has selected the managed care plans for the MMA program through its competitive bidding process, the state will submit a report to CMS no later than October 31, 2013, that will include:

a) The name of the managed care plans selected for each region;

b) For the selected plans, please identify those plans that also provide long term services and supports under the 1915(b)(c) waivers;

c) The names of managed care plans that will not be continuing by region; and,

d) The number of enrolled beneficiaries in each plan that will not be continuing.

39. **Freedom of Choice.** An enrollee's freedom of choice of providers shall be limited to and through whom individuals may seek services, including the EBAP for populations enrolled in the Florida Medicaid Reform demonstration. The state must provide demonstration enrollees access to the FFS delivery systems as necessary to meet the choice requirements as under 42 CFR 438.52.

    a) Beneficiaries also have a choice of at least two regional health plans in each region. While beneficiaries are encouraged to select the same MMA plan as their Medicare Advantage or LTC Plan, it is not a requirement.

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

40. **Specialty Plans.** The contracted plans in the MMA program regions 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 that has been approved by the state as a specialty plan. Specialty plans are designed for a specific population and currently include plans that primarily serve children with chronic conditions or recipients who have been diagnosed with the human immunodeficiency virus or acquired immunodeficiency

syndrome (HIV/AIDS). Participation of specialty plans will be subject to competitive procurement requirements and the aggregate enrollment of all specialty plans in a region may not exceed 10 percent of the enrollees of that region.

The state will identify specialty plans as part of the procurement process and may 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 and/or providers to serve that target population. The state will not approve plans that discriminate against sicker members of a target population.

The state may also contract with Medicare Advantage Organizations, to serve Medicare-Medicaid enrollees, authorized by the Centers for Medicare & Medicaid Services.

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

a) Appropriate integrated provider network of primary care physicians and specialists who are trained to provide services for a particular condition or population. The network should 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).

b) 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.

c) Defined network of facilities that are used for inpatient care, including the use of accredited tertiary hospitals and hospitals that have been designated for specific conditions (e.g., end stage renal disease centers, comprehensive hemophilia centers).

d) Availability of specialty pharmacies, where appropriate.

e) Availability of a range of community-based care options as alternatives to hospitalization and institutionalization.

f) Clearly defined coordination of care component that links and shares information between and among the primary care provider, the specialists, and the patient to appropriately manage co-morbidities.

g) Use of evidence-based clinical guidelines in the management of the disorder.

h) Development of a care plan and involvement of the patient in the development and management of the care plan, as appropriate.

i) Development and implementation of a disease management program specific to the specialty population(s) or disease state(s), including a specialized process for transition of enrollees from disease management services outside of the plan to the plan's disease management program.

41. **Incentives are included for plans that exceed Agency defined quality measures.** Plans that exceed such measures during a reporting period may retain an additional 1 percent of revenue.

42. **Requirements for Special Populations.**

a) HIV Specialty Plans

i. The state will mandatorily enroll Medicaid beneficiaries identified with a diagnosis of HIV or AIDS to a specialty plan, where available, and when the beneficiary does not select an MMA plan during the 30 day choice period. These beneficiaries may be identified with a combination of diagnosis codes on current claims; HIV or AIDS prescription medications; and laboratory tests and results.

ii. The state will notify beneficiaries identified with a diagnosis of HIV or AIDS in writing that the beneficiary must select an MMA plan during the 30 day choice period or the beneficiary will be assigned to a specialty plan available in his or her region. The notification will provide the beneficiary with information regarding the benefits of enrolling in a specialty plan and the 90 day period to make another plan selection without cause.

iii. When making assignments to an HIV/AIDS specialty plan, the state will consider the beneficiary's PCP and/or current prescriber of HIV or AIDS medications.

iv. When making assignments to HIV/AIDS specialty plans and the beneficiary's PCP or current prescriber of HIV or AIDS medications is not known or is not an enrolled provider with a specialty plan, the state will assign the beneficiary to a specialty plan available on a rotating basis.

v. When making assignments to HIV/AIDS specialty plans of beneficiaries who are determined to have co-morbid conditions, the state may assign the beneficiary to the most appropriate specialty plan available in the beneficiary's region.

b) Children's Specialty Plans

i. The State may elect to contract with Children's Specialty Plans to serve Foster Care Children. These plans will have special requirements for immediate assessment, care coordination, and treatment of Foster Care Children. The Children's Specialty Plans are required to furnish EPSDT for Foster Care Children and follow the State's medication formulary for first year of the MMA Program.

ii. During the plan selection period, the Foster Care child's legal guardian may choose to enroll in an MMA health plan or the Children's Specialty Plans that are available in the child's region.

iii. Should a Foster Care child's legal guardian fail to make an affirmative selection of an MMA health plan, the state may enroll the foster care child into the Children's Specialty Plan available in the region.

X. CONSUMER PROTECTIONS

43. **Medical Care Advisory Committee.** In accordance with 42 C.F.R. §431.12, the state must maintain its Medical Care Advisory Committee (MCAC) to advise the Medicaid agency about health and medical care services. The state must ensure that the MCAC is comprised of the representatives set forth in 42 C.F.R. §431.12(d). The state must ensure that the MCAC includes representation of at least four beneficiaries at all times and report to CMS any vacant beneficiary slots that are not filled within 90 days of the date of this amendment or within 90 days of becoming vacant. The state may submit justification to CMS for an unfilled beneficiary slot after 90 days and CMS may grant an exception to this requirement at CMS' discretion. The MCAC must present recommendations and suggestions to the state on the state's comprehensive quality strategy, as described in STC 118.

Subpopulation Advisory Committees. In addition to the MCAC, the state must convene smaller advisory committees that meet on a regular basis (at least quarterly) to focus on subpopulations, including, but not limited to: beneficiaries receiving managed long-term services and supports; beneficiaries with HIV/AIDS; children, including safeguards and performance measures related to foster children and the provision of dental care to all children; and beneficiaries receiving behavioral health/substance use disorder services.

Each advisory committee must include representation from relevant advocacy organizations, as well as beneficiaries. Each advisory committee must present recommendations and suggestions to the state on the state's comprehensive strategy, as set forth in STC 118. In addition, each advisory committee must provide input to the state on the consumer report cards, set forth in STC 115.

44. **Appointment Assistance.** The state must provide, or ensure the provision of, necessary assistance with transportation and with scheduling appointments for medical, dental, vision, hearing, and mental health.

45. **Attempts To Gain an Accurate Beneficiary Address.** The state shall implement the CMS approved process for return mail tracking. The state will use information gained from return mail to make additional outreach attempts through other methods (phone, email, etc.) or complete other beneficiary address analysis from previous claims to strengthen efforts to obtain a valid address.

46. **Verification of Beneficiary's Health plan Enrollment**. The state shall utilize and publicize for health plan network and non-network providers the following eligibility verification processes for beneficiaries' eligibility to be verified so that beneficiaries will not be turned away for services if the beneficiary does not have a card or presents the incorrect card. Providers with a valid Medicaid provider number may use any of the following options to determine enrollee eligibility:

    a) Utilize the Medicaid Eligibility Verification System (MEVS): eligibility transactions may be submitted using computer software supplied by the vendor, via a point of sale device similar to those used for credit card transactions, over the telephone using a voice response system, or other possibilities depending on what the MEVS vendor offers;
    b) Perform single transactions (individual verifications) or batch transactions via a secure area on the Medicaid fiscal agent's web portal;
    c) Utilize the Automated Voice Response System (AVRS): providers enter information via a touchtone telephone and it generates a report with all of the eligibility information for a particular recipient, which can be faxed to the provider's fax machine;
    d) Submit eligibility transactions via the Electronic Data Interchange (EDI);
    e) Contact the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799; or,
    f) Contact their local Medicaid area office for assistance.

47. **Call Center Availability**. The state must keep the existing (non-continuing) health plan call centers open for the first month of implementation to direct callers to either the state, the enrollment broker, or their new health plan.

48. **Sample Notification Letters**. The state must send sample beneficiary notification letters to the existing Medicaid providers, either through direct mailing, posted on the MMA program website, or other widely distributed method, so providers are informed of what is being told to the beneficiaries regarding their transition to the MMA program.

49. **Educational Tour and Outreach for Beneficiaries, Providers, and Stakeholders**.

    a) The state must develop a comprehensive outreach plan to include strategies for communicating with beneficiaries throughout the implementation process. The outreach plan should identify ways in which the state will work collaboratively with beneficiaries, and stakeholders, including the enrollment broker, choice counseling entities, and any other group providing enrollment support for beneficiaries or providers through written notice distribution, outgoing phone calls or other method. The state must initiate beneficiary outreach at least 90 days prior to the implementation of the MMA program in a region and continue through the first 90 days after the implementation of the MMA program.

b) The state must develop a comprehensive outreach plan to include strategies for communicating with providers throughout the implementation process. The outreach plan should identify ways in which the state will work collaboratively with providers and health plans to address providers' questions and concerns regarding implementation. Communication and technical assistance to providers should include webinars, trainings on various topics, Q &A documents, and telephone assistance as applicable.

50. **Continuation of Care During the Transition Period.** Beneficiaries whose health plans will not continue in their region under the MMA program may continue to receive services from their treating provider for up to 60 calendar days after their enrollment effective date under their new MMA health plan.

a) Communication regarding the continuation of services will be publicized through the State's outreach and community strategy to beneficiaries, providers, and the general public.

b) Health plans will be required to authorize services and reimburse providers whether the provider is contracted with the health plans or an out of network provider.

c) If the health plan has not contracted with the treating provider, the health plan must notify enrollees before the 90 day disenrollment period has ended, that they will not be able to continue with the treating provider and provide the option to either:

i. Continue services with a network provider; or,
ii. Disenroll for cause.

51. **Operated Call Center Operations**. The state must operate a call center(s) independent of the health plans for the duration of the demonstration. This can be achieved either by providing the call center directly or through the enrollment broker or other state contracted entities. Call center operations should be able to help enrollees in making independent decisions about plan choice, and be able to voice complaints about each of the health plans independent of the health plans.

52. **Call Center Response Statistics**. During the first 30 days of implementation the state must review all call center response statistics daily to ensure all contracted entities are meeting service level agreements in their contracts. If deficiencies are found, the state and the entity must determine how they will remedy the deficiency as soon as possible. After the first 30 days, if all entities are consistently meeting requirements, the state can lessen the review of call center statistics, but must still review all statistics at least weekly for the first 60 days of implementation. Data and information regarding call center statistics, including beneficiary questions and concerns, must be made available to CMS upon request.

53. **Auto-assignment Algorithm Review**. The state must review the outcomes of the auto-assignment algorithm, and if a health plan is found to get a larger number of beneficiaries

associated with no match to an existing provider relationship due to a more limited network, that entity will not be able to receive as many auto-assignees until such time as the network has improved.

54. **Implementation Calls with the Health Plans.** The state must develop a schedule of calls with health plans during implementation of MMA program to discuss any issues that arise. The state must submit a copy of the schedule of implementation calls to CMS and allow CMS the opportunity to participate in the state's implementation calls with health plans. The calls should cover all health plans operations and determine plans for correcting any issues as quickly as possible. For the first 60 days in which the region transitions to the MMA program CMS will require weekly reporting of issues encountered and plans for and status of resolution during the Implementation Monitoring conference calls specified in STC 89.

55. **State Review of Beneficiary Complaints, Grievances, and Appeals**. During the initial implementation of MMA program, the state must review complaint, grievance, and appeal logs for each health plan and data from the state or health plan operated incident management system, to understand what issues beneficiaries and providers are having with each of the health plans. The state will use this information to implement any immediate corrective actions necessary. The state must review these statistics at least weekly for the first 60 days in which the region transitions to the MMA program. The state will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports as specified in STC 90. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

XI. CHOICE COUNSELING

56. **Choice Counseling Defined.** The state shall contract for choice counselor services in Reform Counties and the MMA program regions to provide full and complete information about managed care plans choices. The state will ensure a choice counseling system that promotes and improves health literacy and provides information to reduce minority health disparities through outreach activities.

57. **Choice-Counseling Materials.** Through the choice counselor the state offers 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.

58. **Choice Counseling Information.** The state or the state's administrator provides information on selecting a managed care plan. The state or the state's designated choice counselor provides information about each plan's coverage in accordance with federal requirements. Information includes but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. In addition, the state may supplement coverage information by providing

performance information on each plan. The supplement information may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance data. To ensure the information is as helpful as possible, the state may synthesize information into a coherent rating system.

59. **Delivery of Choice Counseling Materials.** Choice counseling materials will be provided in a variety of ways including the internet, print, telephone, and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when 5 percent of the county speaks a language other than English. Choice counseling shall also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY, without charge to the enrollee.

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

XII. ENHANCED BENEFITS ACCOUNT PROGRAM UNDER MEDICAID REFORM AND HEALTHY BEHAVIORS PROGRAM UNDER THE MMA PROGRAM

61. **Medicaid Reform Enhanced Benefits Account Program Defined.** The EBAP provides incentives to capitated managed care plan or FFS PSN enrollees for participating in state defined activities that promote healthy behaviors. An individual who participates in a state defined activity that promotes healthy behaviors earns credits that are posted to an individual's account. Earned credits may be used for health care related expenditures as approved under the EBAP and defined in Section 1905 of the Act. EBAP is available only in Medicaid Reform counties prior to implementation of the managed care plan's Healthy Behaviors programs under the MMA program. The only exception is that recipients who have accrued Enhanced Benefits credits will be able to access the credits for up to one year.

62. **Medicaid Reform EBAP Administration Overview.** The state will maintain a list of activities that 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. 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 post earned credits into an account for use by the enrollee. Additional credits may be earned as the

enrollee participates in additional activities. In no instance will the individual receive cash.

63. **Medicaid Reform Participants Earning Enhanced Benefits Accounts Defined**. All enrollees in a Reform plan, including mandatory and voluntary enrollees, will be eligible to participate in activities to earn enhanced benefits for the duration of their enrollment. The exception to this provision is at the time of EBAP phase out as discussed in Section III, "General Program Requirements".

64. **Expansion Population for the Continuation of the EBAP.** In Medicaid in Reform counties, individuals who lose eligibility or transition to MMAP will continue to have limited eligibility under this demonstration for a period of one year. This population retains eligibility under the demonstration solely to access accrued funds in their individual enhanced benefits account for a period of one year. Individuals who lose eligibility for Medicaid will receive no other benefits than those available through the EBAP. This population is limited to individuals who have accrued funds in an individual enhanced benefit account. Upon implementation of the MMA program, recipients who have accrued credits under Medicaid Reform will be able to access those credits for up to one year. These individuals are identified as demonstration Population A.

65. **Healthy Behaviors Programs Under the MMA Program.** Through its procurement process, the state must require the managed care plans operating in the MMA program counties to establish Healthy Behaviors programs to encourage and reward healthy behaviors. For Medicare and Medicaid recipients who are enrolled in both an MMA plan and a Medicare Advantage plan, the MMA plan must coordinate their Healthy Behaviors programs with the Medicare Advantage plan to ensure proper coordination.

    a) The state must monitor to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse treatment plan that meet all state requirements.

    b) Programs administered by plans must comply with all applicable laws, including fraud and abuse laws that fall within the purview of the United States Department of Health and Human Services, Office of Inspector General (OIG). Plans are encouraged to seek an advisory opinion from OIG once the specifics of their Healthy Behaviors programs are determined**.**

66. **Participant Access to Credits Under Medicaid Reform (EBAP) and MMA (Healthy Behaviors Programs).**

    a) Beneficiaries have access to EBAP accounts under Medicaid Reform as follows:

        i. Individuals who are enrolled in a Medicaid Reform plan and who have participated in a state defined activity that promotes healthy behavior and thus have a positive balance;

ii. Individuals who no longer are enrolled in a Medicaid Reform plan (either due to loss of eligibility or change of eligibility to an eligibility group not authorized to participate; or transition to a Healthy Behaviors programs through their MMA plan) but who have a positive balance in their account;

iii. Regardless of the reason for the loss of eligibility to participate in the demonstration, an individual participating in EBAP may retain access to any earned funds for a maximum of one year, except in the instance of termination of the demonstration. Upon implementation of the MMA program, recipients who have accrued credits under Medicaid Reform will be able to access those credits for up to one year; and,

iv. If an individual subsequently regains Medicaid eligibility, the enrollee will be eligible to participate in the EBAP and earn additional credits until the MMA program has been implemented in the regional where the individual resides.

b) Beneficiaries have access to Healthy Behaviors accounts under MMA as follows: Managed care plans will not be required to transfer earned credits or rewards or provide access to earned credits or rewards if a beneficiary changes managed care plans. For beneficiaries who lose Medicaid eligibility, plans will be required to maintain record of the credits for 180 days and re-instate earned credits or rewards if the beneficiary re-establishes eligibility and re-enrolls with the plan within 180 days.

67. **Federal Financial Participation (FFP) Under Both Medicaid reform and MMA Program.** The state shall claim FFP at the time the enhanced benefits credits are utilized by an enrollee to purchase an approved product, supply, or service.

68. **Enhanced Benefits Account Program Contracts Under Medicaid Reform.** The state shall provide CMS a copy of any procurement document to administer the EBAP. In addition, the state will provide the CMS Regional Office a copy of the contract for approval, to administer the EBAP. At a minimum, the contract will specify the scope of work, duration of the contract, and the amount of contract.

69. **Effective and Efficient Administration of the Enhanced Benefits Accounts Program Under Medicaid Reform and the Healthy Behaviors programs under the MMA Program.** The state will submit documentation related to EBAP and Healthy Behaviors eligibility activities, respective earnings for each activity, eligible health related expenditures and access to account information in the Annual Report and Quarterly Reports as discussed in Section XVI, General Reporting Requirements.

XIII. ADDITIONAL PROGRAMS

70. **Transition of two current 1915(b)(3) programs and one state plan program.** On January 1, 2014 programs currently authorized under Florida's Section 1915(b) Medicaid Managed Care Waiver, will expire and instead be authorized under this demonstration. These programs will be available in all parts of the state.

a. The Healthy Start Program - authorized as 1915(b)(3) services under Florida's Section 1915(b) Medicaid Managed Care Waiver;

b. The Program for All Inclusive Care for Children (a component of the Children's Medical Services Network) – authorized as 1915(b)(3) services under Florida's Section 1915(b) Medicaid Managed Care Waiver; and

c. The Comprehensive Hemophilia Program authorized as state plan covered service under Florida's Section 1915(b) Medicaid Managed Care Waiver.

71. **Healthy Start Program.** The Healthy Start program is available statewide for eligible Medicaid recipients. The Healthy Start program is comprised of the following two components:

(a) MomCare: includes outreach and case management services for all women presumptively eligible and eligible for Medicaid under SOBRA. The MomCare component is mandatory for these women as long as they are eligible for Medicaid, and offers initial outreach to facilitate enrollment with a qualified prenatal care provider for early and continuous health care, Healthy Start prenatal risk screening and WIC services. Recipients may disenroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources, family planning services, Medicaid coverage for the infant and the need to select a primary care physician for the infant.

(b) Healthy Start Coordinated System of Care: includes outreach and case management services for eligible pregnant women and children identified at risk through the Healthy Start program. These services are voluntary and are available for all Medicaid pregnant women and children up to the age of 3 who are identified to be at risk for a poor birth outcome, poor health and poor developmental outcomes. The services vary, dependent on need and may include: information, education and referral on identified risks, assessment, case coordination, childbirth education, parenting education, tobacco cessation, breastfeeding education, nutritional counseling and psychosocial counseling. The goal of this component is to increase the intensity and duration of service to Healthy Start beneficiaries.

72. **Program for All Inclusive Care for Children (Children's Medical Services Network).** Participation in the PACC program is voluntary. The PACC program provides the following pediatric palliative care support services to children enrolled in the CMS Network who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider (PCP).

a) Support Counseling – Face-to-face support counseling for child and family unit in the home, school or hospice facility, provided by a licensed therapist with documented pediatric training and experience.

b) Expressive Therapies – Music, art, and play therapies relating to the care and treatment of the child and provided by registered or board certified providers with pediatric training and experience.

c) Respite Support – Inpatient respite in a licensed hospice facility or in-home respite for patients who require justified supervision and care provided by RN, LPN, or HHA with pediatric experience. This service is limited to 168 hours per year.

d) Hospice Nursing Services – Assessment, pain and symptom management, and in-home nursing when the experience, skill, and knowledge of a trained pediatric hospice nurse is justified.

e) Personal Care – This service is to be used when a hospice trained provider is justified and requires specialized experience, skill, and knowledge to benefit the child who is experiencing pain or emotional trauma due to their medical condition.

f) Pain and Symptom Management – Consultation provided by a CMS Network approved physician with experience and training in pediatric pain and symptom management.

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

73. **Comprehensive Hemophilia Disease Management Program.** The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized service whereby recipients who have a diagnosis of hemophilia or von Willebrand disease and are enrolled in the fee-for-service (FFS) system, the MediPass program (the MediPass program will be terminated with the implementation of the MMA program), FFS PSN, capitated PSN or an HMO, are required to obtain pharmaceutical services and products related to factor replacement therapy from one of the two contracted vendors. In addition to product distribution, the program provides pharmacy benefit management, direct beneficiary contact, personalized education, enhanced monitoring, and direct support of beneficiaries in the event of hospitalization, at no additional cost to the state. Enrollees have access to a registered nurse and licensed pharmacist 24 hours a day, seven days a week. The enrollees also have access to medical care and treatment through their usual and customary networks, with no restrictions on services or providers, and receive pharmacy products other than those related to factor replacement therapy via the usual and customary networks without restriction, as well.

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

XIV. LOW INCOME POOL

74. **Low Income Pool Definition.** The LIP provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. The LIP is also designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim as described in paragraph 84(a). The LIP consists of a capped annual allotment of $1 billion total computable for each year of the demonstration extension.

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

76. **LIP Reimbursement and Funding Methodology.** LIP permissible expenditures defining state authorized expenditures from and entities eligible to receive LIP reimbursement are defined in the Reimbursement and Funding Methodology document dated October 2012. This document limits LIP payments to allowable costs incurred by providers and requires the state to reconcile LIP payments to auditable costs. CMS is currently working with the state on reconciliations for DY 4. The state submitted to CMS Reconciliations for DY 5 on May 31, 2013.

    CMS has determined that payments made to providers in DY 1-3 are in excess of allowable costs; therefore, the state is required to return the federal portion of $104,351,578 total computable expenditures claimed in excess of allowable cost and/or in excess of applicable cost limits. This will be achieved through a reduction of the amount available to be claimed under the pool by $104 million the first year of the state's intended renewal period in the event the demonstration is renewed or, by issuing a disallowance to the state.

    If the reconciliations for DY 4 identify LIP payments in excess of allowable cost consistent with paragraph 75 and the Reimbursement and Funding Methodology document implementing the LIP, the state must modify the Reimbursement and Funding Methodology applicable to DY 6 to ensure that payments under the LIP are consistent with the LIP goals and that providers will not receive payments that exceed their costs utilizing the cost reconciliation information to inform payment methodology modifications. CMS will also work with the state to identify modifications to the Methodology to address any cost documentation or audit processes necessary to fully meet cost reconciliation requirements. Any changes required by CMS will be applied

prospectively to payments and audits for the next demonstration year. The state may claim LIP payments based on the existing Methodology during the 60 day reconciliation finalization period. Claims after that period can only be made on the modified final approved Reimbursement and Funding Methodology approved by March 1, 2012. Changes to the Reimbursement and Funding Methodology document requested by the state must be approved by CMS and are only approved for one demonstration year.

DY 4 and 5 reconciliation results will be reflected in the Reimbursement and Funding Methodology documents for DY 9 and 10. If the final reconciliations for DY 4 and 5 result in a finding that payments were made in excess of cost, the Reimbursement and Funding Methodology must be further modified to ensure that payments in the next demonstration year will not result in payments in excess of allowable cost, particularly methodologies that provide payments to providers that have received payments during any prior demonstration year in excess of allowable costs as defined in paragraph 75 and the Reimbursement and Funding Methodology. Any required modifications to the DY 7 annual Reimbursement and Funding Methodology document must be approved by CMS before FFP will be made available for the next demonstration year's LIP payments.

The state shall by February 1 of each year of the demonstration, submit a protocol to ensure that the payment methodologies for distributing LIP funds to providers supports the goals of the LIP as described in paragraph 74 and that providers receiving LIP payments do not receive payments in excess of their cost of providing services. FFP is not available for LIP payments until the protocol is finalized and approved by CMS.

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

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

79. **Low Income Pool Permissible Expenditures 10 percent Sub Cap.** Up to 10 percent of the capped annual allotment of the LIP funds may be used for hospital expenditures other than payments to providers for the provision of health care services to an uninsured or underinsured individual. Payments from this sub-cap may be used for the improvement or continuation of specialty health care services that benefit the uninsured and underinsured, such as capacity building and infrastructure, hospital trauma services, hospital neonatal services, rural hospital services, pediatric hospital services, teaching or

specialty hospital services, or safety net providers. The reimbursement methodologies for these expenditures and the non-federal share of funding for such expenditures will be defined in the Reimbursement and Funding Methodology Document as discussed in paragraph 76.

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

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

82. **Permissible Sources of Funding Criteria.** Sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. Federal funds received from other federal programs (unless expressly authorized by federal statute to be used for matching purposes) shall be impermissible.

XV. LOW INCOME POOL MILESTONES

83. **Aggregate LIP Funding.** At the beginning of each DY, $1 billion in LIP funds will be available to the state. These amounts will be reduced by any milestone penalties that are assessed by CMS. Two tiers of milestones, as described in paragraph's 84 and 85, must be met for the state and facilities to have access to 100 percent of the annual LIP funds. Funds not distributed in a DY may be rolled over to the next DY.

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

a) Development and implementation of a state initiative that requires Florida to allocate $50 million in total LIP funding in DY 7 and DY 8 to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Initiatives must broadly drive from the three overarching goals of CMS' Three-Part Aim.

i. Better care for individuals including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;
ii. Better health for populations by addressing areas such as poor nutrition, physical inactivity, and substance abuse; and,
iii. Reducing per-capita costs.

Expenditures incurred under this program must be permissible LIP expenditures as defined under Section, Low Income Pool. The state will utilize DY 6 to develop the program. The program must be implemented with LIP funds allocated and expenditures incurred in DYs 7 and 8.

b) Timely submission of all hospital, FQHC, and County Health Department LIP reconciliations in the format required per the LIP Reimbursement and Funding Methodology protocol. The state shall submit to CMS, within 30 days from the date of formal approval of the waiver extension request, a schedule for the completion of the LIP Provider Access Systems (PAS) reconciliations for the 3-year extension period. CMS will provide comments to the state on the reconciliation schedules within 30 days. The state will submit the final reconciliation schedule to CMS within 60 days of the original submission date.

c) Timely submission of all demonstration deliverables as described in the STCs including the submission of Quarterly and Annual Reports.

d) Development and submission of an annual "Milestone Statistics and Findings Report" and a "Primary Care and Alternative Delivery Systems Expenditure Report". Within 60 days following the acceptance of the terms and conditions, the state must submit templates for these reports and anticipated timelines for report submissions.

e) Timely submission of all other reporting requirements under Sections XVI, General reporting Requirements, XIX, Evaluation of the Demonstration and XX, Measurement of Quality of Access to Care and Improvement.

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

85. **Tier-Two Milestones.** Tier-two milestones initiatives must drive from the three overarching goals of the Three-Part Aim as described in paragraph 84(a). The initiatives will focus specifically on: infrastructure development; innovation and redesign; and population focused improvement. Participating facilities must implement new, or enhance existing, health care initiatives, investments, or activities with the goal of meaningfully improving the quality of care and the health of populations served (including low income populations) and meet established hospital specific targets, to receive 100 percent of allocated LIP funding. Tier-two milestones apply to facilities that receive the largest annual allocations of LIP funds and put at risk 3.5 percent of each of these facility's annual LIP allocation. The milestones apply to the 15 hospitals which are allocated the largest annual amounts in LIP funding. If the total annual LIP funds allocated for the 15 hospitals, do not total at least $700 million, the population of hospitals must be expanded until $700 million is reached.

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

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

A top 15 hospital cannot select quality improvement initiatives under which it is currently receiving or may be eligible to receive other federal dollars unless the LIP outcome goals are enhanced over previously established targets.

Within 90 days following the acceptance of the terms and conditions, CMS and the state will, through a collaborative process, finalize the plan and procedures including the specific health care initiatives, investments, and activities, and the applicable standards, measures, and evaluation measures and protocols that will allow for the implementation and monitoring of tier-two milestones and evaluation of the impact of these initiatives. The specific metrics chosen should support the measurements required in paragraph 110(a)(vii-ix). CMS must approve the final plan and procedures which will require that tier-two facilities receiving funds in SFY 2011-2012 must submit its milestone plan by March 31, 2012, including baseline data and outcome targets, to meet their DY 6 (SFY 2011-2012) tier-two milestone.

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

a) Infrastructure Development – Investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services. Examples of such initiatives are:
   i. Increase in Primary Care capacity including residency programs and externships;
   ii. Introduction of Telemedicine;
   iii. Enhanced Interpretation Services and Culturally Competent Care; and,
   iv. Enhanced Performance Improvement Capacity;

b) Innovation and Redesign – Investments in new and innovative models of care delivery that have the potential to make significant, demonstrated improvements in patient experience, cost, and disease management. Examples of such initiatives are:
   i. Expansion of Medical Homes;
   ii. Primary Care Redesign; and,
   iii. Redesign for Efficiencies (e.g. Program Integrity).

c) Population-focused Improvement – Investments in enhancing care delivery for the 5 – 10 highest burden (morbidity, cost, prevalence, etc) conditions/services present for the population in question. Examples of such initiatives are:
   i. Improved Diabetes Care Management and Outcomes;
   ii. Improved Chronic Care Management and Outcomes;

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

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

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

XVI. GENERAL REPORTING REQUIREMENTS

86. **General Financial Requirements.** The state must comply with all general financial requirements set forth in Section XVII.

87. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements set forth in Section XVIII.

88. **Managed Care Data Requirements.** All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

a) Encounter Data (Health Plan Responsibilities) – The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.

b) Encounter Data (State Responsibilities) - The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

c) Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new managed care organizations, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of demonstration enrollees.

d) Submission of Encounter Data to CMS - The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with federal law. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

89. **Monitoring Calls.** During the implementation phase of the MMA program, CMS will schedule weekly implementation calls that will continue until at least 60 days after the last region is implemented. The state and CMS shall jointly develop the agenda for the calls.

a) CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include but are not limited to, health plan operations (such as contract amendments, rate certifications, plans withdrawing or entering the demonstration), health care delivery, enrollment, quality of care, access, benefit packages including EPSDT, dental care, the Enhanced Benefits Account Program (until MMA program is implemented), Healthy Behaviors Programs, choice counseling activities, audits, lawsuits, financial reporting related to budget neutrality issues, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting that impact the demonstration. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

90. **Quarterly Reports.** The state must submit progress reports, to include the items outlined below (see also Attachment A), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

a) An updated budget neutrality monitoring spreadsheet including enrollment data, member month data, and expenditure data in the format provided by CMS. As described in STC 94(d)(iv), reports on the state's progress in developing the necessary CMS-64 reporting system changes to accommodate the MMA program, should the 1115 demonstration be renewed;

b) A discussion of events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, including but not limited to: approval and contracting with new plans; geographic expansion; benefits; enrollment and disenrollment; quality of care; access; pertinent legislative or litigation activity; and other operational issues;

   A discussion of network adequacy reporting from medical and dental plans including customer service reporting; average speed of answer at the plans and call abandonment rates; summary of capitated managed care plan and FFS PSNs appeals for the quarter including overturn rate and any trends identified; enrollee complaints and grievance reports to determine any trends; and summary analysis of the managed care plans critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation;

c) Action plans for addressing any policy, administrative, or budget issues identified;

d) State efforts related to the collection and verification of encounter data, and utilization data;

e) Medical Loss Ratio data pertaining to Medicaid plan operations in demonstration counties;

f) Enrollment data disaggregated by plan and by the following specifications: eligibility category, TANF and SSI, total number of enrollees; market share; and percentage change in enrollment by plan. In addition, the state will provide a summary of voluntary and mandatory selection rates and disenrollment data;

g) Choice of plans and capacity of plans participating in the Reform and MMA Program counties including the number of beneficiaries who made an affirmative choice verses being auto-enrolled into a plan;

h) Efforts to promote alignment and integration with Medicare for Medicare-Medicaid eligible individuals, including the number of participants who are in an MMA plan and an affiliated Medicare Advantage plan.

i) Documentation of the efforts to promote full and timely access to medical, vision, hearing, dental, mental health, and other care and services covered under the EPSDT benefit for children, as well as services required by the Florida Department of Children and Families for foster care children.

j) Low Income Pool activities and associated expenditures;

k) Activities related to choice counseling including efforts to improve health literacy and the methods used to obtain public input including recipient focus groups;

l) Participation rates in the Enhanced Benefits Account Program until implementation of the MMA program and the Healthy Behaviors Programs after MMA implementation. This shall include: participation levels; summary of activities and the associated expenditures; number of accounts established including active participants and individuals who continue to retain access to funds in an account but no longer actively participate; estimated quarterly deposits in accounts, and expenditures from the account;

m) Status of managed care plan performance, initiatives and activities, as measured by HEDIS, CAHPs and other quality metrics;

n) Description of the implementation progress of expanding managed care, challenges encountered, and how the challenges were addressed;

o) Progress toward the demonstration goals; and,

p) Evaluation activities including the contracting status with an independent evaluator.

91. **Annual Report.** The state must submit an annual report no later than 120 days after the close of each DY. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

The report must documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly reports required under paragraph 90 and include a section that provides qualitative and quantitative data that describes the impact the LIP has had on the rate of uninsurance in Florida since implementation of the demonstration. In addition, the annual report must address the following items.

a) Yearly enrollment reports must be included for all demonstration enrollees for each demonstration year (DY) that include the member months, as required to evaluate compliance with the budget neutral agreement, and the total number of unique enrollees within the DY.

b) Pursuant to STC 118, the state must report on the implementation and effectiveness of the updated Comprehensive Quality Strategy as it impacts the demonstration.

c) Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups,

annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and managed care plan compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure.

d) Medicare-Medicaid Eligible Enrollees. The state must report on the efforts to promote alignment and integration with Medicare for dual-eligible individuals.

e) Children including foster care children. The state must report on the efforts to promote full and timely access to medical, vision, hearing, dental, mental health and other care and services covered under the EPSDT benefits for children, as well as services required by the Florida Department of Children and Families for foster care children.

f) Managed Care Expansion. The state must report on the implementation progress, challenges encountered, and how the challenges were addressed, as specified in section X, Consumer Protections.

g) Evaluation. The state must report on the contracting status with an independent evaluator.

92. **Transition Plan.** The state is required to prepare and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act (ACA) for individuals enrolled in the demonstration, including how the state plans to coordinate the transition of these individuals to a coverage option available under the ACA without interruption in coverage to the maximum extent possible. The state must submit a draft final report to CMS by July 1, 2012, with progress updates included in each quarterly report required by paragraph 90. On June 24, 2012, the state notified CMS that a transition was not applicable to the demonstration.

XVII. GENERAL FINANCIAL REQUIREMENTS

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

94. **Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit.** All expenditures for health care services for demonstration participants and categories, as

described in section (d), are subject to the budget neutrality agreement. The following describes the reporting of expenditures subject to the budget agreement:

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

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

c) Pharmacy Rebates. The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS-64.9 form (to avoid double counting). Each rebate amount must be distributed as state and Federal revenue consistent with the federal matching rates under which the claim was paid.

d) Use of Waiver Forms. For each DY, a waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter, using the waiver names listed below. The waiver names designate the waiver forms in the MBES/CBES system to report Title XIX expenditures associated with the demonstration.

i. **Through June 30, 2014, the current MEGs (MEG 1:** SSI**, MEG 2:** TANF, **MEG 3:** Low Income Pool) with the following currently approved population mappings will be utilized for the CMS-64 reporting purposes. Demonstration Populations 1 and 7 represent Reform counties and include all enrolled mandatory and voluntary participants. Populations 2 through 5 represent non-reform counties and include all individuals who would be mandatory participants if Reform was effective in that county.

(A) :**Demonstration Population 1 (MEG 1)** – (Aged/Disabled): Aged and disabled demonstration enrollees.

(B) **Demonstration Population 2 (MEG 1)** – (FMR-SSI+DsEldw/oMcare): Aged and disabled individuals without Medicare in non-Reform counties who would be required to enroll in the demonstration.

(C) **Demonstration Population 3 (MEG 2)** – (FMR-TANF): Individuals qualifying under TANF in non-Reform counties who would be required to enroll in the demonstration.

(D) **Demonstration Population 4 (MEG 2**) – (FMR-SOBRA/FC): Individuals qualifying under SOBRA or Foster Care in non-Reform counties who would be required to enroll in the demonstration.

(E) **Demonstration Population 5 (MEG 1)** – (FMR->65): Individuals 65 and older in non-Reform counties who would be required to enroll in the demonstration.

(F) **Demonstration Population 6 (MEG 3)** – (Low Income Pool): Demonstration expenditures allowed under the Low Income Pool.

(G) **Demonstration Population 7 (MEG 2)** – (TANF & related grp): TANF demonstration enrollees.

ii. Beginning no earlier than January 1, 2014, expenditures associated with mandatory and voluntary MMA enrollees will be reported using the currently approved classification as defined in (i) above.

iii. **If the 1115 Research and Demonstration Waiver is renewed,** the CMS-64 will reflect the expenditures for statewide MMA populations, including those attributable to MMA voluntary populations. The following names and definitions will be utilized for the CMS-64 reporting purposes:

(A) MEG 1: SSI
(B) MEG 2: TANF
(C) MEG 3: Low Income Pool

At this time, the CMS-64 will reflect the expenditures for statewide MMA populations, including those attributable to MMA voluntary populations.

iv. **Progress Reports.** The state must submit quarterly progress reports on its progress in developing new programming logic to accommodate the necessary CMS-64 reporting system changes, should the 1115 demonstration be renewed.

e) Excluded Services. The following services are excluded from the demonstration:

i. ID Waiver (HCBS Waiver Services);
ii. Home Safe Net (Behavioral Services) until the MMA program is implemented;
iii. Behavioral Health Overlays Services (Services Only) until the MMA program is implemented;

iv. ICF/IID Institutional Services;
v. Family & Supported Living Waiver Services;
vi. Katie Beckett Model Waiver Services;
vii. Brain & Spinal Cord Waiver Services; and
viii. School Based Admin Claiming.

f) Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance of 100 percent for claimed the amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may exclude from the budget neutrality test for this demonstration the portion of the increase for which the federal government pays 100 percent. These amounts should be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

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

h) Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

i) Claiming Period. All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

95. **Reporting Member Months.** The following describes the reporting of member months for demonstration Populations.

    a) For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the Quarterly Report required under paragraph 90, the actual number of eligible member months for the three MEGs described in paragraph 106 the state must provide CMS, upon request, eligible member months by population as defined in paragraph 94(d). The state must submit a statement accompanying the Quarterly Report which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revision.

    b) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

    c) Starting January 1, 2014, the state must begin reporting separate member month totals for mandatory and voluntary individuals enrolled in MMA that are not already represented in the member month reporting in place prior to that date. The member months must be subtotaled according to the MEGs defined in subparagraph (d)(i) above.

96. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year (FFY) on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and state and Local Administrative Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

97. **Extent of FFP.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the following, subject to the limits described in Section XVI:

    a) Administrative costs associated with the administration of the demonstration;
    b) Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration;

c) Net expenditures and prior period adjustments for Medicaid Reform Plan premiums paid to managed care entities and fee for service coverage options;
d) Net Expenditures associated with the LIP, as described in Section XIII; and,
e) Net Expenditures associated with the EBAP.

Pursuant to standard Medicaid financing rules, FFP is excluded for payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution) pursuant to the payment exclusion in paragraph (A) following section 1905(a)(29) of the Act.

In addition, pursuant to standard Medicaid financing rules, FFP is excluded for payments with respect to care or services for any individual who has not attained 65 year of age and who is a patient in an institution for mental diseases pursuant to the payment exclusion in paragraph (B) following section 1905(a)(29) of the Act, except as provided in section 1905(a)(16) for inpatient psychiatric services for individuals under age 21.

98. **Sources of Non-Federal Share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a) CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
b) The state shall provide information to CMS regarding all sources of the non-federal share of funding for any amendments that impact the financial status of the program.
c) The state assures that all health care related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

99. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of the demonstration expenditures are met:

a) Units of government, including governmentally-operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration;
b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures;
c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general

revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match;

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments; and,

e) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

100. **MSIS Data Submission.** The state shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards, including the required transition to T-MSIS.

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

102. **Program Integrity.** The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XVIII. MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the demonstration period. Paragraphs 103 and 104 specify the two independent financial caps on the amount of federal Title XIX funding that the state may receive on expenditures subject to the budget neutrality limit as defined in paragraph 94. Federal financial payments for the Medicaid Reform aspects of the demonstration are limited by a Per Member Per Month (PMPM) method cap and the payments for the LIP aspects are limited by an aggregate cap.

103. **Budget Neutrality Limit for the LIP.** The LIP amount is capped at $1 billion total computable for each DY. Funds not distributed in a DY may be rolled over to the next DY. The federal share of the annual $1 billion total computable is the maximum amount of FFP that the state may receive during the extension period for the types of

Medicaid expenditures for the LIP. For each DY, the federal share will be calculated using the FMAP rate(s) applicable to that year.

104. **Limit on PMPM Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on the Medicaid and demonstration expenditures identified in paragraph 94 during the approval period of the demonstration. The limit is determined using a PMPM method. The budget neutrality targets are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire demonstration. All data supplied by the state to CMS is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS' assessment of the state's compliance with these limits will be done using the CMS-64 Report from the MBES/CBES System.

105. **Risk.** The state shall be at risk for the per capita cost of demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees. By providing FFP for all demonstration enrollees, the state will not be at risk for changing economic conditions which impact enrollment levels. However, by placing the state at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

106. **Budget Neutrality Expenditure Limit.** The following describes the method for calculating the budget neutrality expenditure limit for the demonstration. Demonstration expenditures are defined under the following Medicaid Eligibility Groups (MEGs) as referenced in paragraph 94(d):

a) MEG 1: SSI
b) MEG 2: TANF
c) MEG 3 : Low Income Pool

For the purpose of calculating the overall PMPM expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The federal share of this estimate will represent the maximum amount of FFP that the state may receive during the extension period for the types of Medicaid expenditures for the SSI and TANF MEGs. Budget neutrality calculations for both with and without waiver expenditures are applied on a statewide basis. For each DY, the federal share will be calculated using the FMAP rate(s) applicable to that year. For the purpose of monitoring budget neutrality, the $1 billion in annual LIP expenditures is considered as both with and without waiver expenditures.

a) Projecting Service Expenditures - Each yearly estimate of Medicaid Reform service expenditures will be the cost projections for the SSI and TANF MEGs in sub-paragraph (b) below. The annual budget estimate for each MEG will be the product of the projected PMPM cost for the MEG, times the actual number of eligible

member months as reported to CMS by the state under the guidelines set forth in paragraph 95.

b) Projected PMPM Cost - The PMPM costs for each MEG used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below. The PMPM estimates for SSI MEG and TANF MEG are applied to the member months reported based on the standards in place as of June 2013. The PMPM estimates for SSI MEG and TANF MEG are applied to the member months reported for MMA enrollees, discussed in paragraph 95(c).

Demonstration Year	SSI MEG	Trend Rate	TANF MEG	Trend Rate	SSI MEG MMA	TANF MEG MMA
DY 1 (SFY 2007)	$ 948.79	8.0%	$199.48	8.0%		
DY 2 (SFY 2008)	$1,024.69	8.0%	$215.44	8.0%		
DY 3 (SFY 2009)	$1,106.67	8.0%	$232.68	8.0%		
DY 4 (SFY 2010)	$1,195.20	8.0%	$251.29	8.0%		
DY 5 (SFY 2011)	$1,290.82	8.0%	$271.39	8.0%		
DY 6 (SFY 2012)	$1,356.65	5.1%	$285.77	5.3%		
DY 7 (SFY 2013)	$1,425.84	5.1%	$300.92	5.3%		
DY 8 (SFY 2014)	$1,498.56	5.1%	$316.87	5.3%	$294.01	$583.64

107. **How the Limit will be Applied**. The limits as defined in paragraphs 103 through 106 will apply to the actual expenditures for the demonstration, as reported by the state under Section XVIII. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess federal funds will be returned to CMS. There will be no new limit placed on the FFP that the state can claim for expenditures for recipients and program categories not listed.

108. **Impermissible DSH, Taxes or Donations**. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through state Medicaid Director letters, other memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act.

Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

109. **PMPM Expenditure Review.** CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, the state will calculate an annual expenditure target for the completed year and report it to CMS as part of the reporting guidelines in paragraph 91. This amount will be compared with the actual FFP claimed by the state under budget neutrality. Using the schedule below as a guide for the PCCM budget limit, if the state exceeds the cumulative target, they shall submit a corrective action plan to CMS for approval. The state will subsequently implement the approved program.

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

XIX. EVALUATION OF THE DEMONSTRATION

110. **Submission of Draft Evaluation Design Update.** The state must submit to CMS for approval, within 120 days of the approval date of the MMA amendment, a draft evaluation design update that builds and improves upon the evaluation design that was approved by CMS on October 31, 2012. At a minimum, the draft design must include a discussion of the goals, objectives and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on beneficiaries, providers, plans, market areas and public expenditures. The analysis plan must cover all elements in paragraph 112). The updated design should be described in sufficient detail to determine that it is scientifically rigorous. The data strategy must be thoroughly documented. The updated design should accommodate and reflect the staggered implementation of the MMA program to produce more reliable estimates of program impacts. The design should describe how the evaluation and reporting will develop and be maintained to assure its scientific rigor and completion. In summary, the demonstration evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation and reporting of findings. Among the characteristics of rigor that will be met are the use of best available data; controls for and reporting of the limitations of data and their effects on results; and the generalizability of results.

The updated design must describe the state's process to contract with an independent evaluator, ensuring no conflict of interest.

The design, including the budget and adequacy of approach, to assure the evaluation meets the requirements of 112(a), is subject to CMS approval. The budget and approach must be adequate to support the scale and rigor reflected in the paragraph

above. The rigor also described above also applies as appropriate throughout Sections XIX and XX.

111. **Cooperation with Federal Evaluators.** Should HHS undertake an evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the evaluator selected by HHS. The state shall submit the required data to HHS or its contractor

112. **Evaluation Design.**

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

i. The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
ii. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
iii. Participation in the Enhanced Benefits Account Program (EBAP) and the MMA plans' Healthy Behaviors programs (upon implementation of the MMA program) and its effect on participant behavior or health status;
iv. The impact of the demonstration as a deterrent against Medicaid fraud and abuse;
v. The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
vi. The effect of LIP funding on disparities in the provision of healthcare services, both geographically and by population groups;
vii. The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
viii. The impact of Tier-One and Tier-Two milestone initiatives on population health;
ix. The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care;
x. The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care. Baseline data to evaluate this domain will be collected prior to June 30, 2014;
xi. The effect of having separate managed care programs for acute care and LTC services on the demonstration's impact as a deterrent against Medicaid fraud and abuse. Baseline data to evaluate this domain will be collected prior to June 30, 2014;
xii. The effect of transitioning the EBAP program from direct state operation to the MMA plans' Healthy Behaviors programs; and,

xiii. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual-eligible individuals.

b) Measures. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:

i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);

ii. The measure steward;

iii. The baseline value for each measure;

iv. The sampling methodology for assessing these outcomes; and

v. The methods of data collection.

c) Sources of Measures. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).

d) The evaluation design must also discuss the data sources used, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

113. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design and the draft MMA evaluation strategy within 60 days of receipt, and the state shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation final report by October 31, 2014. The state must submit the final evaluation report within 60 days after receipt of CMS' comments.

The state must submit to CMS a draft of the evaluation final report by October 31, 2014. The final report must include the following:

a) An executive summary;

b) A description of the demonstration, including programmatic goals, interventions implemented, and resulting impact of these interventions;

c) A summary of the evaluation design employed, including hypotheses, study design, measures, data sources, and analyses;

d) A description of the population included in the evaluation (by age, gender, race/ethnicity, etc.);

e) Final evaluation findings, including a discussion of the findings (interpretation and policy context); and

f) Successes, challenges, and lessons learned.

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

114. **External Quality Review (EQR).** The state is required to meet all requirements for external quality review (EQR) found in 42 C.F.R. Part 438, subpart E. In addition to routine encounter data validation processes that take place at the MCO/PIHP and state level, the state must maintain its contract with its external quality review organization (EQRO) to require the independent validation of encounter data for all MCOs and PIHPs at a minimum of once every three years.

    The state should generally have available its final EQR technical report to CMS and the public, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), by April 30th of each year, for data collected within the prior 15 months. This submission timeframe will align with the collection and annual reporting on managed care data by the Secretary of Health and Human Services each September 30th, which is a requirement under the Affordable Care Act [Sec. 2701 (d)(2)].

115. **Consumer Health Plan Report Cards.** On an annual basis, the state must create and make readily available to beneficiaries, providers, and other interested stakeholders, a health plan report card, in a format compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d), that is based on performance data on each health plan included in the annual EQR technical report. Each health plan report card must be posted on the state's website and present an easily understandable summary of quality, access, and timeliness regarding the performance of each participating health plan. The report cards must also address the performance of subcontracted dental plans.

116. **Performance Improvement Projects (PIPs).** The state must require each health plan to commit to improving care in the following focus areas, which have the significant potential for achieving the demonstration's goals of improving patient care, population health, and reducing per capita Medicaid expenditure.

a) A PIP combining a focus on improving prenatal care and well-child visits in the first 15 months;
b) A PIP focused on preventive dental care for children;
c) An administrative PIP, topic of which must be approved by the state; and
d) A choice of PIP in one of the following topic areas:
    a. Population health issues (such as diabetes, hypertension and asthma) within a specific geographic area that have been identified as in need of improvement;
    b. Integrating primary care and behavioral health; and
    c. Reducing preventable readmissions .

Each PIP must be conducted in accordance with 42 C.F.R. §§ 438.358 and 438.240.

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

117. **Measurement Activities.** The state must ensure that each participating health plan is accountable for metrics on quality and access, including measures to track progress in identified quality improvement focus areas, measures to track quality broadly, and measures to track access. The state must set performance targets that equal or exceed the 75th percentile national Medicaid performance level.

The state must collect data and information on dental care utilization rates, the CMS Medicaid and CHIP adult and child core measures, and must align with other existing federal measure sets where possible to ensure ongoing monitoring of individual well-being and plan performance. The state will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

118. **Comprehensive State Quality Strategy.** The state shall adopt and implement a comprehensive and holistic, continuous quality improvement strategy that focuses on all aspects of quality improvement in Medicaid, including FFS populations; FFS PSNs ; and capitated managed care plans, including Medicaid Reform, and the MMA program, and managed long term services and supports. The Comprehensive Quality Strategy (CQS) shall meet all the requirements of 42 CFR 438 Subparts D and E and must include section 1915(c) HCBS waivers' corrective action plan quality components.

a) The CQS must also address the following elements:
    i. The state's goals for improvement, identified through claims and encounter data, quality metrics and expenditure data. The goals should align with the three part aim but should be more specific in identifying specific pathways for the state to achieve these goals.
    ii. The associated interventions for improvement in the goals.
    iii. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets

where possible. The metrics should go beyond HEDIS and CAHPS data, and should reflect cost of care.

iv. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, each health plan, and each direct health services provider. The state will work with CMS to further define what types of metrics will be measured for direct service providers.

v. The specific methodology for determining benchmark and target performance on these metrics for each aggregated level identified above (state, plan and provider).

vi. Performance improvement accountability – i.e., the state must determine if the current plans for financial incentives adequately align with the specific goals and targeted performance, and whether enhancements to these incentives are necessary (increased or restructured financial incentives, in-kind incentives, contract management, etc.). The state must present the findings of the determination to CMS.

vii. Specific metrics related to each population covered by the Medicaid program. HCBS performance measures, consistent with the corrective action plan, in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, and assuring there are qualified providers and appropriate HCBS settings.

viii. Monitoring and evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, and also a rigorous and independent evaluation of the demonstration, as described in STC 110. The evaluation should reflect all the programs covered by the CQS as mentioned above.

ix. HIV evaluation. The state will evaluate, in accordance with the rigor described in STC 110, the HIV population to determine if there are better health outcomes for HIV positive beneficiaries in the HIV specialty plan as compared to in a MMA health plan. The state will also evaluate medication adherence and improved care and care coordination as a result of being enrolled in the HIV specialty plan.

b) The CQS should include a timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the re-basing of performance data.

c) The CQS must include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.

d) The first draft of this CQS is due to CMS no later than 120 days following the approval of this amendment/renewal. CMS will review this draft and provide feedback to the state. The state must revise and resubmit the CQS to CMS for approval within 45 days of receipt of CMS comment. The state must revise (and submit to CMS for review and approval) their CQS whenever significant changes are

made to the associated Medicaid programs and the content of the CQS. Revisions to the CQS must be submitted to CMS for review and approval within 90 days of approval of the amendment authorizing the implementation of MMAP.

Any further revisions must be submitted accordingly:

i. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver renewals); and/or
ii. Changes to an existing, approved CQS due to fundamental changes to the CQS must be submitted for review and approval to CMS no later than 60 days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than 60 days following the changes.

e) The state must solicit for and obtain the input of beneficiaries, the Medical Care Advisory Committee (MCAC) as set forth in STC 43, and other stakeholders in the development of its CQS and make the initial CQS, as well as any significant revisions, available for public comment prior to implementation. Pursuant to STC 91, Annual Report, the state must also provide CMS with annual reports on the implementation and effectiveness of their CQS as it impacts the demonstration.

f) As required by 42 C.F.R. §438.360(b)(4), the state must identify in the CQS any standards for which the EQRO will use information from private accreditation reviews to complete the compliance review portion of EQR for participating MCOs or PIHPs. The state must, by means of a crosswalk included in the CQS, set forth each standard that the state deems as duplicative to those addressed under accreditation and explain its rationale for why the standards are duplicative.

g) Upon approval by CMS, the state will finalize the CQS to be fully compliant with Section 508 of the Rehabilitation Act (29 U.S.C. § 794d).

XXI. SCHEDULE OF STATE DELIVERABLES

Date	Deliverable	STC Reference
60 days following the end of the quarter	Quarterly Progress Reports	Section XVI, STC 90
120 days following the end of the demonstration year	Annual Report	Section XVI, STC 91
30 days following the end of the quarter	Quarterly Expenditure Reports	Section XVII, STC 93
90 days following the award of the	Managed Care Policies	Section III, STC 17 (a), (b), (d), and (e)

demonstration		
October 31, 2013	MMA Program Implementation Schedule	Section VIII, STC 35(a)
30 days in advance of implementation in each region	Implementation regional reports	Section VIII, STC 35.f)
7 months following the end of each quarter	Quarterly Medical Loss Ratio Reporting by the capitated plans for Demonstration Counties	Section III, STC 17 (c)
30 days following award of the demonstration	Premium Assistance Transition Plan	Section XVI, STC 92
July 1, 2012	ACA Transition Plan	Section XVI, STC 92
60 days following acceptance of the STCs	LIP Reconciliations for DYs 1, 2, and 3	Section XIV, STC 76
30 days following acceptance of the STCs	LIP Reconciliation Schedule for DYs 6, 7, and 8	Section XV, STC 84(b)
60 days following acceptance of the STCs	Templates for LIP Milestone and Expenditure Reports	Section XV, STC 84(d)
120 days following the award of the MMA amendment	Draft Evaluation Design	Section XIX, STC 110
120 days following the award of the MMA amendment	Draft Comprehensive Quality Strategy	Section XX, STC 118
Various	LIP Milestone Deliverables	Section XV, STCs 84 and 85

ATTACHMENT A

Under paragraph 90, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework showing the broad categories of information to be reported and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include all items described in paragraph 90 and an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – Florida Managed Medical Assistance Program

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 6 (7/1/2011 – 6/30/2012)
Federal Fiscal Quarter: 4/2011 (7/1/2011 – 9/30/2011)

Introduction

Please provide information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0". Enrollment counts should be person counts.

Demonstration Populations (as hard coded in the Form CMS-64)	Total as of end of Current Quarter	Voluntary Disenrolled in Current Quarter	Involuntary Disenrolled in Current Quarter
Population 1 - Aged/Disabled			
Population 2 - FMR-SSI+DsEldw/oMcare			
Population 3 - FMR-TANF			
Population 4 - FMR-SOBRA/FC			
Population 5 - FMR->65			
Population 7 - TANF & related grp			

After January 1, 2014, expenditures for statewide MMA populations, including those attributable to MMA voluntary populations are to be included in this reporting.			

Outreach/Innovative Activities
Summarize outreach activities including but not limited to Choice Counseling, MMA implementation outreach and educational tour and/or promising practices for the current quarter.

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to: approval and contracting with new plans; benefit changes; legislative activity; Healthy Behaviors program benefits by health plan and participation rates; network adequacy including customer service reporting; complaints, grievances and appeals; reporting on managed care plans critical incidents, efforts to promote alignment or integration for Medicare-Medicaid eligible individuals.

Consumer Issues

Provide a summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Identify and address any appeals related to medical necessity under the EPSDT benefit.

Quality Assurance /Monitoring Activities

Identify any quality assurance/monitoring activity in the current quarter, including but not limited to MCAC recommendations, PIP progress and Consumer Health Plan Report Cards.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and Form CMS-64 reporting for the current quarter. Identify the state's actions to address these issues.

Enclosures/Attachments
Identify by Title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, Title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

WAIVERS AND AUTHORITIES FOR FLORIDA'S MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

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

TITLE: **Managed Medical Assistance Program**

AWARDEE: **Agency for Health Care Administration**

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

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act (Act) and shall enable the state to implement the Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled Medicaid Reform) consistent with the approved Special Terms and Conditions (STCs). These waivers are effective beginning December 16, 2011, through June 30, 2014.

Title XIX Waivers

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

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

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

   To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits. Also this waiver is to permit Florida to offer different benefits to demonstration Population A than to the categorically needy group.

3. **Income and Resource Test** **Section 1902(a)(10)(C)(i)**

   To enable Florida to exclude funds in an enhanced benefit account from the income and resource tests established under state and federal law for purposes of determining Medicaid eligibility.

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

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

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration December 16, 2011, through June 30, 2014, be regarded as expenditures under the state's Title XIX plan.

The following expenditure authorities shall enable Florida to operate the Florida Managed Medical Assistance program section 1115 demonstration (formerly titled Medicaid Reform).

1. **Demonstration Population A.** Expenditures for health care related costs not to exceed the amount of the individual's enhanced benefit account, for individuals who lose eligibility for Medicaid or demonstration Population A benefits. This expansion population shall be allowed to retain access to the enhanced benefits account for up to 1 year, except in the instance of termination of the demonstration.

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

3. Expenditures made by Florida for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, subject to the restrictions placed on the Low Income Pool, as defined in the STCs.

4. Expenditures for benefits under the enhanced benefits account program.

5. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program as previously approved under the 1915(b) waiver (control #FL-01) and as described in STCs 71 and 72.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

In order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authorities described above, the following Medicaid requirements are not applicable to the expenditure authorities:

1. Provision of Medical Assistance **Section 1902(a)(10)(A)**

To enable Florida to limit the medical assistance for demonstration Population A to health care related costs not to exceed the amount of the individual's enhanced benefit account.

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

To enable Florida to vary the amount, duration, and scope of benefits offered to demonstration Population A from that offered to other beneficiaries under the plan, and to enable benefits for Population A to be non-comparable to those offered to the categorically needy group.

3. Provider Agreements **Section 1902(a)(27)**

To permit the provision of care by entities who have not executed a provider agreement with the State Medicaid Agency for the purpose of providing enhanced benefits under the enhanced benefits account program.

EXHIBIT "I"

State of Florida
Long-Range Financial Outlook
Fiscal Year 2013-14 through 2015-16

Fall 2012 Report
As Adopted by the Legislative Budget Commission

Jointly prepared by the following:
The Senate Committee on Budget
The House Appropriations Committee
The Legislative Office of Economic and Demographic Research

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Long-Range Financial Outlook

What is the Outlook?

In 2006, Florida voters adopted a constitutional amendment that requires the development of a Long-Range Financial Outlook, setting out recommended fiscal strategies for the state and its departments in order to assist the legislature in making budget decisions. The Legislative Budget Commission is required to issue the Outlook by September 15th of each year. The 2012 Outlook is the sixth document developed in accordance with the provisions of Article III, Section 19(c)(1) of the Florida Constitution.

Ultimately, the Outlook is a tool that provides an opportunity to both avoid future budget problems and maintain financial stability between state fiscal years. The Outlook accomplishes this by providing a longer-range picture of the state's fiscal position that integrates projections of the major programs driving Florida's annual budget requirements with the revenue estimates. In this regard, the projections primarily reflect current-law spending requirements and tax provisions. It also includes budgetary, economic, demographic, and debt analyses to provide a framework for the financial projections and covers the upcoming three fiscal years: in this version, 2013-14, 2014-15, and 2015-16. It does this by using anticipated revenues and expenditures in the current year (2012-13) as the starting point.

THE OUTLOOK DOES NOT PURPORT TO PREDICT THE OVERALL FUNDING LEVELS OF FUTURE STATE BUDGETS OR THE FINAL AMOUNT OF FUNDS TO BE ALLOCATED TO THE RESPECTIVE BUDGET AREAS. THIS IS BECAUSE VERY FEW ASSUMPTIONS ARE MADE REGARDING FUTURE LEGISLATIVE POLICY DECISIONS OR DISCRETIONARY SPENDING, MAKING THIS DOCUMENT SIMPLY A REASONABLE BASELINE. IN THIS REGARD, ALL FUNDS REMAINING AFTER THE BUDGET DRIVERS AND OTHER KEY ISSUES ARE FULLY FUNDED FOR THAT YEAR ARE CARRIED FORWARD INTO THE FOLLOWING FISCAL YEAR.

Who produced it?

The Outlook was jointly developed by the Senate Committee on Budget, the House Appropriations Committee, and the Legislative Office of Economic and Demographic Research.

How was the Outlook developed?

- All major programs that have historically driven significant increases in the State's budget like Medicaid and the Florida Education Finance Program, as well

as constitutional requirements such as Class Size Reduction, were reviewed and individually analyzed.

- Forecasts of future workload and enrollment increases were developed for each of the major cost drivers using a variety of methods including projections from Consensus Estimating Conferences and historical funding averages. An additional round of Summer Estimating Conferences was established specifically to facilitate the availability of up-to-date information.

- Costs were applied to the projected workload requirements based on recent legislative budget decisions.

- Exceptional funding needs—the fiscal impact of special issues outside of normal workload and caseload requirements—were identified and addressed when necessary for state operations.

- The various cost requirements were then aggregated by major fund type and compared to revenue estimates for those funds.

Understanding the Outlook

- The Outlook contains budget drivers that are grouped by policy areas that roughly correspond to the Appropriations Bill format required by the constitution. Also included are separate sections for Potential Constitutional Issues, Revenue Projections, Florida's Economic Outlook, Florida's Demographic Projections and the Census, Debt Analysis and a comparison of costs versus revenues.

- The descriptions for the various budget drivers contain projections for the applicable major state-supported programs, an identification of the assumptions behind the projections, and a description of any significant policy issues associated with the projections.

- Emphasis is placed on recurring programs, those programs that the state is expected or required to continue from year to year.

- Estimates for several ongoing programs historically funded with nonrecurring funds are also included in the Outlook. Even though funded with nonrecurring funds, these programs are viewed as annual "must funds" by most legislators and are therefore identified as major cost drivers.

- Revenue projections specifically cover the General Revenue Fund, the Educational Enhancement Trust Fund (lottery and slots proceeds devoted to education), the State School Trust Fund and the Tobacco Settlement Trust Fund. Other trust funds have been estimated and discussed in the areas where they are relevant to the expenditure forecast.

- All revenue projections include recurring and nonrecurring amounts.

- The tables used to project fund balances (General Revenue, Educational Enhancement, State School, and Tobacco Settlement) include estimates for both anticipated revenue collections and expenditures. They summarize the information contained and discussed in the rest of the document.

- Budget drivers have been categorized as either "*Critical Needs*" (mandatory increases based on estimating conferences, and other essential needs) and "*Other High Priority Needs*" (historically funded issues). *Critical Needs* can be thought of as the absolute minimum the state must do absent significant law or structural changes, and *Other High Priority Needs* in combination with the *Critical Needs* form a highly conservative continuation budget.

- For the purposes of this Outlook, prior expenditures from depleted trust funds have been redirected to the General Revenue Fund when the underlying activities are ongoing in nature.

- Fiscal strategies are discussed when necessary to close a projected budget gap. They demonstrate the impact of varying policy decisions on the baseline projection. When deployed, the unique assumptions used for these scenarios are not built into the rest of the Outlook.

B. Key Aspects of the Expenditure Demands

- Critical Needs are mandatory increases based on estimating conferences and other essential items. The twenty-two Critical Needs drivers represent the minimum cost to fund the budget without significant programmatic changes. For the General Revenue Fund, the greatest burden occurs in Fiscal Year 2013-14.

- The twenty-five Other High Priority Needs drivers are historically funded issues that are typically viewed as "must funds" in normal budget years. Like the Critical Needs, the greatest General Revenue burden occurs in the first year.

DOLLAR VALUE OF
CRITICAL AND OTHER HIGH PRIORITY NEEDS

GENERAL REVENUE FUND	FY 2013-14	FY 2014-15	FY 2015-16
Total Tier 1 - Critical Needs	573.7	522.6	219.6
Total - Other High Priority Needs	1016.8	711.6	795.0
Total Tier 2 - Critical and Other High Priority Needs	1590.5	1234.2	1014.6

- For each year, the Other High Priority Needs represent a greater percentage of the total needs than do the Critical Needs. Critical Needs have the greatest share of the total in Fiscal Year 2014-15, but still less than 50 percent. This may allow the Legislature to have greater flexibility in putting together future budgets.

PERCENTAGE OF
TOTAL CRITICAL AND OTHER HIGH PRIORITY NEEDS

GENERAL REVENUE FUND	FY 2013-14	FY 2014-15	FY 2015-16
Total Tier 1 - Critical Needs	36.1%	42.3%	21.6%
Total - Other High Priority Needs	63.9%	57.7%	78.4%
Total Tier 2 - Critical and Other High Priority Needs	100.0%	100.0%	100.0%

- Not only are the projected expenditures for Critical and Other High Priority Needs different over time, but the various policy areas also differ in their resource demands by year. Most areas are relatively balanced in magnitude over time, but the Pre K-12 Education policy area has dramatically different needs across the three years as the ad valorem tax roll changes. Still other areas have much larger needs in the first year (Criminal Justice and Administered Funds – Statewide

proactively opt out. For purposes of these requirements, a "full-time employee" is an employee who works an average of at least 30 hours per week.

Medicaid

The Medicaid program (Title XIX of the Social Security Act) provides health care coverage to certain persons who qualify as low-income elderly, disabled, or families with dependent children. Medicaid is jointly funded by the state with federal matching funds.

PPACA modifies the basis for determining Medicaid eligibility and—as passed—called for states to expand eligibility to all persons with incomes up to 138 percent of the federal poverty level (FPL), effective January 1, 2014, in order for states to continue receiving federal Medicaid funds. Initially, this new eligibility group would be funded at a match rate of 100 percent federal funds, but the federal match would phase down over time to 90 percent beginning in January 2020. The phase-down of the federal match would begin in January 2017. PPACA's federal match rates apply only to Medicaid recipients who become eligible solely due to PPACA's new income thresholds. Expenditures for recipients who qualify for Medicaid under the state's preexisting eligibility parameters would draw the traditional federal match rate, which in Florida is 57.73 percent for Fiscal Year 2012-13 and is forecast at 58.62 percent for Fiscal Year 2013-14.

U.S. Supreme Court Ruling

PPACA was the subject of several lawsuits that sought to have the law stricken based upon constitutional grounds. PPACA was largely ruled constitutional by the U.S. Supreme Court on June 28, 2012, except for the law's requirement for Medicaid expansion, which was ruled by the court to be an unconstitutional coercion by the federal government. As such, based on the court's ruling, the law's requirement for states to expand Medicaid eligibility to 138 percent of the FPL in January 2014 has effectively been rendered optional. However, PPACA's mandate for most U.S. citizens and legal residents to have health care coverage was upheld by the court, as were PPACA's fees to be assessed on employers as described above.

Impacts on Medicaid

PPACA could affect the state's Medicaid caseloads and expenditures in at least the following ways:

1. Under Florida's current Medicaid program, income thresholds for most Medicaid eligibility groups are significantly less than 138 percent of the FPL. If the state chooses to fully implement PPACA's new eligibility standards, Medicaid caseloads would resultantly begin increasing in January 2014 and would include previously uninsured individuals as well as persons likely to terminate their preexisting health coverage after becoming eligible for Medicaid (a.k.a. "crowd out"). Medicaid expenditures would increase correspondingly; however, the federal government would cover 100 percent of the costs for recipients who become eligible solely due to PPACA's new standards, but only until January 2017. See below for the federal

match for such recipients during and beyond the Outlook's forecast years. While there would be long-term costs to the state from a decision to participate in the expansion program, they would not directly affect the Outlook period.

Calendar Year	Federal Match for Expansion Population
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020	90%

2. PPACA requires states to increase Medicaid reimbursement rates for primary care services provided by primary care practitioners to 100 percent of the Medicare reimbursement rate during calendar years 2013 and 2014. The match rate for this increase is 100 percent federally funded for those two calendar years. That is, the federal government will fund 100 percent of the difference between Medicare rates and the state's preexisting rates during 2013 and 2014. The Supreme Court ruling does not address this issue; therefore the rate increase is not optional for the state during this period. As such, this requirement will increase total Medicaid expenditures beginning January 1, 2013, through December 31, 2014, thereby impacting the Outlook's forecast years. Since this increase is not optional, the impact has been included in the Critical Needs section of the Outlook as Driver #9. In addition, the Outlook includes Driver #31 in Other High Priority Needs to continue the rate increase beyond the mandatory period for the existing program—see discussion under Risks in this section.

The following estimates represent the potential effects on the Medicaid program to fully implement PPACA's optional Medicaid eligibility standards (138 percent of FPL) in the forecast years as agreed upon by the August 14, 2012 Social Services Estimating Conference. The estimates include assumptions as to how the potentially eligible populations will present for services as well as timeframes for the phase-in of the new beneficiaries. The estimates do not include costs associated with individuals who are eligible for Medicaid under the current state standards but are not enrolled. While the conference believes that added expenditures to the existing program are likely under the PPACA provisions, only the state's maximum exposure can be estimated.

The following tables represent estimated increases to the Medicaid[5] program resulting from the optional expansion and the associated cost of continuing the primary care practitioners' rate increase for the duration of the Outlook period for this population. In

[5] The impact to the Kidcare program is shown separately. Kidcare is the state's children's health insurance program provided under the federal Children's Health Insurance Program (CHIP) - Title XXI of the Social Security Act.

addition, costs are shown for the total program (existing and optional) if the expansion were implemented. For estimates that do not include the optional effects of PPACA, see Driver #9 in the Critical Needs section of the Outlook.

Medicaid Caseload Estimates Including Optional Medicaid Expansion

	2012-13	2013-14	2014-15	2015-16
Medicaid Caseload (Existing Program)	3,317,084	3,465,110	3,568,625	3,668,488
Title XIX: Expansion to 138%		397,030	603,255	679,686
Title XIX: Crowd Out		66,250	132,501	165,626
Title XIX: Kidcare Transfer		64,753	65,094	67,138
*Total Optional Medicaid Expansion**		528,033	800,850	912,450
Total Caseload	**3,317,084**	**3,993,143**	**4,369,475**	**4,580,938**
Total Incremental Increase		676,059	376,332	211,463
Percent		20.38%	9.42%	4.84%
Incremental Increase Due to Optional Expansion		528,033	272,817	111,600
Percent Increase Due to Optional Expansion			51.67%	13.94%

*NOTE: Reflects Medicaid program impact only; does not include the offset in the Kidcare program.

Medicaid Program Expenditure Estimate for Optional Expansion*
(dollars in millions)

	2012-13	2013-14	2014-15	2015-16
State Revenue		$16.3	$33.0	$34.4
Incremental Increase		$16.3	$16.7	$1.4
Percent			102.52%	4.31%
Federal Match		$940.9	$2,917.8	$3,336.1
Incremental Increase		$940.9	$1,977.0	$418.3
Percent			210.12%	14.34%
Total Increase		$957.2	$2,950.8	$3,370.5
Incremental Increase		$957.2	$1,993.6	$419.8
Percent			208.29%	14.23%

*NOTE: Increases in state Medicaid expenditures represent Kidcare children moving into Medicaid and the associated cost of continuing the primary care practitioners' rate increase for the duration of the Outlook period for this population. The corresponding decreases in state Kidcare expenditures are shown on a separate table.

One future PPACA impact that should be highlighted is the treatment of employees paid from Other Personal Services (OPS). Current state law specifically excludes OPS employees from participating in the state employee health insurance program. However, under PPACA, the state will be required to extend health insurance coverage to all of its "full-time" employees (those who work an average of 30 or more hours per week) or be subject to significant penalties. Assuming that one or more OPS employees meet the definition of "full-time" employees under the federal law, the state would be subject to a penalty of $312.6 million annually if the prohibition remains and OPS employees are not provided insurance coverage meeting the minimum requirements of federal law. The estimated penalty is $2,000 for each "full-time" employee participating in the state employee health insurance program. In lieu of paying the federal penalty, the state may allow OPS employees that are considered "full-time" employees under federal law to participate in the Program. This change would result in increased premium revenues and increased expenses for the state employee health insurance program. The total expense to the State Employees' Group Health Insurance Trust Fund associated with including OPS personnel who are considered "full-time" employees under PPACA, in the first full fiscal year of implementation (Fiscal Year 2014-15) is projected at slightly less than $40 million.

The incremental cost to the state, including the state universities, of the PPACA provisions that become effective after July 1, 2013, is estimated to be $47.6 million in Fiscal Year 2013-14, $77.0 million in Fiscal Year 2014-15 and $18.6 million in Fiscal Year 2015-16. These costs assume 10 percent annual increases in employer paid contributions effective on January 1, 2014; 2015; and 2016, in line with those assumed in Driver #21. Approximately 67 percent of those costs are funded with General Revenue funds and 33 percent with trust funds.

OTHER HIGH PRIORITY NEEDS

PRE K–12 EDUCATION (Drivers #23 – #24)

23. Workload and Enrollment—Florida Education Finance Program (FEFP)

Additional state funds are added to the critical needs funding adjustments to the FEFP for projected enrollment growth to maintain *state* funds per student of $3,559. This adjustment only affects Fiscal Years 2014-15 and 2015-16.

[SEE TABLE ON FOLLOWING PAGE]

HUMAN SERVICES (Drivers #29 – #32)

29. Developmentally Disabled Services

Other high priority needs for the home and community-based waiver include funding for deficits carried forward from Fiscal Year 2011-12. This Outlook includes $21.0 million in nonrecurring General Revenue funds for Fiscal Year 2013-14. This estimate is based upon the Agency for Persons with Disabilities' August 2012 Surplus/Deficit Report.

30. Children and Family Services

The Outlook restores nonrecurring funds in Fiscal Year 2013-14 for maintenance adoption subsidies, community based care, Healthy Families, community projects, and mental health and substance abuse services. The Outlook provides a workload increase for Medicaid waivers services based on four-year averages. This Outlook also addresses a $21.5 million deficit in programs funded with nonrecurring TANF dollars in Fiscal Year 2012-13. These high priority drivers increase General Revenue funds for the Department of Children and Families by $86.4 million for Fiscal Year 2013-14, $13.4 million for Fiscal Year 2014-15 and $13.4 million for Fiscal Year 2015-16.

31. Health Services

For Fiscal Year 2013-14, the Outlook includes $30.0 million in recurring General Revenue funds to restore nonrecurring funding for Hospital Rate reduction buybacks, and includes $2.5 million in recurring General Revenue funds to restore nonrecurring funding for the Florida Healthy Kids Medical Service Payments to maintain 85 percent Medical Loss Ratios. The Outlook provides $0.8 million in nonrecurring General Revenue to continue the Nitrogen Reduction Study, provides $5.5 million in nonrecurring General Revenue to restore TANF-related programs such as Children's Medical Services Early Steps and Family Health programs, and provides $1.8 million in recurring General Revenue to restore nonrecurring funds to County Health Departments due to Tobacco Settlement Trust Fund shortfalls and nonrecurring funding in the Healthy Start program. The Outlook includes $5.0 million in General Revenue in Fiscal Years 2013-14, 2014-15, and 2015-16, for growth in Medicaid waivers in the Department of Elder Affairs and the Department of Health.

The Outlook also includes $173.8 million in recurring General Revenue in Fiscal Year 2014-15 and $171.4 million in recurring General Revenue in Fiscal Year 2015-16 to continue the Primary Care Practitioner Fee Increases initiated under PPACA. As previously stated, the costs for increasing the primary care reimbursement rates is fully funded by the federal government for calendar years 2013 and 2014. The Outlook includes General Revenue matching funds to continue this increase beyond the federally required two-year period.