

Florida Managed Medical Assistance Program

(Project Number 11-W-00206/4)

Public Notice Document

**3-Year Waiver
Extension Request**

**1115 Research and Demonstration Waiver
Florida Agency for Health Care Administration**



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I. Purpose, Goals, and Objectives

A. Statement of Purpose

The Agency for Health Care Administration (Agency) is seeking federal authority to extend Florida Medicaid's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 through June 30, 2020. The MMA program operates statewide and provides primary care, acute medical care, dental care, and behavioral health care for Florida Medicaid recipients through contracts with managed care plans.

The Agency is not proposing any substantive changes in the renewal of the MMA Waiver. The Agency is requesting that the current waiver and expenditure authorities granted by the Centers for Medicare and Medicaid Services (CMS) on October 15, 2015 (and as specified in the Special Terms and Conditions (STCs)) be continued during the waiver extension period for the following programs:

- The MMA program
- The Healthy Start program
- The Program for All Inclusive Care for Children
- The Comprehensive Hemophilia program

The Agency is not requesting waiver or expenditure authorities related to the Low-Income Pool program. The Agency was notified by CMS in June 2015, that the authority for the LIP program would be for two years only (i.e., not extended past June 30, 2017). The Agency is exploring other avenues to continue this level of funding.

To view the current approved STCs, visit

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/docs/mma/FL_MMA_STCs_CMS_Approved_2015-10-15.pdf.

B. Goals and Objectives

The Agency seeks to renew the MMA Waiver to continue to build upon the successes and lessons learned since implementation of the MMA program, and to further the following objectives:

- Promote an integrated health care delivery model that incentivizes quality and efficiency.
- Improve health outcomes through care coordination and recipient engagement in their own health care.
- Improve program performance, particularly improved scores on nationally recognized quality measures (such as Health Plan Effectiveness Data and Information Set).
- Improve access to coordinated care by enrolling all Medicaid recipients in MMA plans except those specifically exempted.
- Enhance access to primary and preventive care through robust provider networks.

- Enhance fiscal predictability and financial management by converting the purchase of Florida Medicaid services to capitated, risk-adjusted, payment systems. Strict financial oversight requirements are established for MMA plans to improve fiscal and program integrity.

These goals and objectives empower recipients, improve provider accountability, facilitate studious governmental program management, and fiscal integrity.

C. Demonstration Components of the Program

The demonstration components of the MMA Waiver are:

- Use of risk-adjusted premiums, which allows distribution of payments to MMA plans based on the health risk of their enrollees resulting in more efficient use of Medicaid dollars by better matching payment to risk. This approach minimizes the phenomenon of “adverse selection” and provides an incentive for MMA plans to take all necessary steps to identify enrollees who have undiagnosed chronic conditions. The MMA plan may receive a higher premium only if an enrollee is diagnosed with a condition that merits the additional premium. Once an MMA plan identifies an enrollee with a chronic condition, it is in the plan’s financial interest to properly manage the enrollee’s condition to avoid the need for higher cost services typical of untreated chronic conditions.
- Implementation of healthy behavior programs through the MMA plans. Managed Medical Assistance plans are required to establish programs that encourage and reward healthy behaviors. The Agency monitors to ensure each MMA plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and an alcohol or substance abuse treatment program.

D. Federal and State Waiver Authority

The following is a historical description of the federal and state authority granted since the waiver was authorized in 2005.

Initial 5-Year Period (2006-2011):

On October 19, 2005, Florida’s 1115 Research and Demonstration Waiver named “Medicaid Reform” was approved by CMS. The program was implemented in Broward and Duval counties on July 1, 2006, and expanded to Baker, Clay, and Nassau counties on July 1, 2007.

Three-Year Extension Period (2011-2014):

On December 15, 2011, the Agency received approval from CMS to extend Florida’s 1115 Medicaid Reform Waiver for the period July 1, 2011 through June 30, 2014.

MMA Waiver Amendment (2014):

On June 14, 2013, the Agency received CMS approval to amend the waiver to terminate the Medicaid Reform program, implement the MMA program, and rename the waiver, “Managed Medical Assistance”. The Reform program was terminated on August 1, 2014 with the implementation of the MMA program.

Three-Year Waiver Extension (2014-2017):

On November 27, 2013, the Agency submitted an extension request to extend authority for the 1115 MMA Waiver for an additional three years (July 31, 2014 - June 30, 2017). The Agency received approval for the three-year extension from CMS on July 31, 2014. The effective dates of the current waiver period are July 31, 2014 through June 30, 2017.

MMA Waiver Amendment (2015):

On October 15, 2015, the Agency received approval to:

1. Allow recipients under the age of 21 years who are receiving Prescribed Pediatric Extended Care services and recipients residing in group home facilities licensed under section 393.067, Florida Statutes (F.S.) to voluntarily enroll in an MMA plan.
2. Enroll newly Medicaid eligible recipients into a managed care plan immediately after their eligibility determination, and to make changes to the auto-assignment criteria.
3. Extend the LIP program through the remainder of the demonstration period ending June 30, 2017.

MMA Waiver Amendment (2016):

On March 28, 2016, the Agency submitted an amendment request to:

1. Allow the Agency flexibility to contract with one to three vendors under the hemophilia program.
2. Include payments for nursing facility services in the MMA capitation rates for MMA enrollees under the age of 18 years.
3. Allow flexibility for specialty plans to conduct Performance Improvement Projects on topics that have more specific impacts to their enrollees, with Agency approval.

Note: The Agency is awaiting federal approval from CMS on this amendment request.

II. Public Notice Process

This section provides a summary of the public notice and input process utilized by the Agency, which complies with the requirements in 42 CFR 431.408.

A. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs¹ located in Florida through written correspondence to solicit input on the waiver extension request. See Attachment I for a copy of the letters.

B. Public Notice Process

The Agency will conduct the public comment period from October 11, 2016 through November 10, 2016.

The Agency notified stakeholders of the public comment period to solicit input on the waiver extension request using the following methods:

- Published public notices in the Florida Administrative Register in compliance with Chapter 120, F.S. on October 6, 2016.
- Emailed information to individuals and organizations from its interested stakeholders list.
- Published Agency health care alerts announcing the public comment period.
- Posted a prominent link on the Agency's Web site to obtain the public notice materials posted at:
http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_extension_2016-10.shtml

C. Public Meetings

The Agency will conduct public meetings during the comment period as listed below.

Individuals who are unable to attend the meetings in person can participate via conference call by using the toll free number provided. During the meetings, the Agency will provide an overview of the MMA program, a brief history of the MMA Waiver, a description of the extension request, and will accept public comments.

Pursuant to the provisions of the Americans with Disabilities Act, any person that requires special accommodations to participate in this workshop/meeting is asked to advise the Agency at least seven days before the workshop/meeting by contacting Heather Morrison at (850) 412-4034, or by email at Heather.Morrison@ahca.myflorida.com.

If you are hearing or speech impaired, please contact the Agency using the Florida Relay Service, 1 (800) 955-8771 (TDD) or 1 (800) 955-8770 (Voice).

¹ The State of Florida has two federally recognized tribes, the Seminole Tribe and Miccosukee Tribe, and does not have any Urban Indian Organizations.

**Table 1
Schedule of Public Meetings**

| Location | Date | Time |
|---|------------------|-------------------------|
| Tallahassee Agency for Health Care Administration 2727 Mahan Drive Building 3 Conference Room A Tallahassee, FL 32308 Conference Line: 1 888 419 5570 Participant Code: 492 773 91 | October 18, 2016 | 2:00 p.m. – 4:00 p.m. |
| Tampa Agency for Health Care Administration 6800 North Dale Mabry Highway Main Training Room Tampa, FL 33614 Conference Line: 1 888 419 5570 Participant Code: 498 282 50 | October 20, 2016 | 11:30 a.m. – 1:00 p.m. |
| Miami Agency for Health Care Administration 8333 NW 53rd St, Suite 200 Doral, FL 33166 Conference Line: 1 888 419 5570 Participant Code: 474 080 47 | October 21, 2016 | 10:00 a.m. – 11:30 a.m. |

D. Submitting Written Comments

Written comments on the waiver extension may be submitted to the Agency during the public comment period as follows:

- Mail:** 1115 MMA Waiver Extension Request
Bureau of Medicaid Policy
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
- Email:** FLMedicaidWaivers@ahca.myflorida.com
- Comment Cards:** Distributed to public meeting attendees.

III. Health Care Delivery System

The MMA program operates statewide and is guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. The MMA program maintains individual choice, increases access, improves quality, efficiency, and fiscal integrity, while stabilizing cost. This section will provide an overview of key features of the MMA program. The Agency is not proposing any substantive changes to the health care delivery system design authorized under the current demonstration.

A. Eligibility

1. **Eligibility for Florida Medicaid:** In order to receive services under the MMA program, an individual must first be determined eligible for Medicaid benefits as set forth in the Title XIX Florida Medicaid State Plan. The Agency is not requesting authority under this demonstration to expand Medicaid eligibility to populations beyond what is currently authorized through its State Plan. All Florida Medicaid eligibility applications are processed in accordance with the approved State Plan.
2. **Eligibility for the MMA Program:** The following individuals are eligible for the MMA program. Mandatory recipients are required to enroll in an MMA plan in order to receive covered Medicaid services. Voluntary recipients are exempt from mandatory enrollment, but may elect to enroll in an MMA plan to receive covered Medicaid services.
 - a. Mandatory Recipients – The following individuals are required to enroll in an MMA plan:

| Table 2 Mandatory Recipients | | | |
|--|---|----------------|------------------------------------|
| Mandatory State Plan Eligibility Groups | Population Description | Funding Stream | CMS-64 Eligibility Group Reporting |
| Infants under the age of 1 year. Population 2 | No more than 206% of the Federal Poverty Level (FPL). | Title XIX | TANF & Related Grp |
| Children ages 1 through 5 years old. Population 2 | No more than 140% of the FPL. | Title XIX | TANF & Related Grp |
| Children ages 6 through 18 years old. Population 2 | No more than 133% of the FPL. | Title XIX | TANF & Related Grp |
| Blind/Disabled Children. Population 1 | Children eligible under Supplemental Security Income (SSI), or deemed to be receiving SSI. | Title XIX | Aged/Disabled |
| IV-E Foster Care and Adoption Subsidy. Population 2 | Children for whom IV-E foster care maintenance payments or adoption subsidy payments are received – no Medicaid income limit. | Title XIX | TANF & Related Grp |
| Pregnant women. Population 2 | Income not exceeding 191% of FPL. | Title XIX | TANF & Related Grp |
| Section 1931 parents or other caretaker relatives. | No more than Aid to Families with Dependent Children | Title XIX | TANF & Related Grp |

| Table 2 Mandatory Recipients | | | |
|---|--|-----------------------|---|
| Mandatory State Plan Eligibility Groups | Population Description | Funding Stream | CMS-64 Eligibility Group Reporting |
| Population 2 | (AFDC) Income Level (Families whose income is no more than about 31% of the FPL or \$486 per month for a family of 3.) | | |
| Aged/Disabled Adults. Population 1 | Individuals receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA). | Title XIX | Aged/Disabled |
| Former foster care children under the age of 26 years. | Individuals who are under the age of 26 years and who were in foster care and receiving Medicaid when they aged out. | Title XIX | TANF & Related Grp |
| Optional State Plan Groups | | | |
| State-funded Foster Care or Adoption assistance under the age of 18 years. Population 2 | Individuals who receive a state Foster Care or adoption subsidy, not under title IV-E. | Title XIX | TANF & Related Grp |
| Individuals eligible under a hospice-related eligibility group. Population 1 | Up to 300% of SSI limit. Income of up to \$2,130 for an individual and \$4,260 for an eligible couple. | Title XIX | Aged/Disabled |
| Institutionalized individuals eligible under the special income level group specified in 42 CFR 435.236. Population 1 | This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category. | Title XIX | Aged/Disabled |
| Institutionalized individuals eligible under the special home and community-based waiver group specified in 42 CFR 435.217. Population 1 | This group includes institutionalized individuals eligible under this special Home and Community Based Services waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category. | Title XIX | Aged/Disabled |

- b. Medicare-Medicaid Eligible Recipients – Individuals fully eligible for both Medicare and Florida Medicaid (dually eligible recipients) are required to enroll in an MMA plan to receive Florida Medicaid covered services. These individuals continue to have their choice of Medicare providers as the MMA program does not impact individuals' Medicare benefits.
- c. Voluntary Recipients – The following individuals are excluded from mandatory enrollment but may choose to enroll in an MMA plan voluntarily:
 - i. Florida Medicaid recipients who have other creditable health care coverage, excluding Medicare.

- ii. Persons eligible for refugee assistance.
 - iii. Florida Medicaid recipients who are residents of an intermediate care facility for individuals with intellectual disabilities, including Sunland Center in Marianna and Tacachale in Gainesville.
 - iv. Florida Medicaid recipients enrolled in the Developmental Disabilities Individual Budgeting (iBudget) home and community-based services waiver pursuant to Chapter 393, F.S., and Florida Medicaid recipients waiting for iBudget waiver services.
 - v. Florida Medicaid recipients residing in a group home facility licensed under Chapter 393, F.S.
 - vi. Children receiving services in a Prescribed Pediatric Extended Care center.
- d. Excluded from MMA Program Participation - The following individuals are excluded from enrollment in an MMA plan under the demonstration:
- i. Individuals who are eligible for emergency Medicaid for aliens.
 - ii. Women who are eligible only for family planning services
 - iii. Women who are eligible through the breast and cervical cancer services program.
 - iv. Individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in State law. (These individuals are inmates who are not eligible for covered services under the State Plan but may be covered as inpatients in a medical institution).
 - v. Individuals who are eligible for the Medically Needy program.

B. Enrollment and Disenrollment

1. Recipient Choice

Recipients have a choice of two or more MMA plans in each region. The Agency assures it complies with section 1932(a)(3) of the SSA and 42 CFR 438.52, relating to choice.

2. Choice Counseling

The Agency contracts with a vendor to process all managed care enrollment and disenrollment requests, and to provide recipients with meaningful information to enable them to make an informed selection among the available plans providing services in their region.

Individuals applying for Florida Medicaid benefits receive information about the MMA plan choices in their region at the time of their application for Medicaid if they meet the criteria for mandatory enrollment in the MMA program.

Individuals are provided with information to encourage an active plan selection electronically (online) or in print, and are given the opportunity to meet or speak with a choice counselor to obtain additional information in making a choice. The Agency's choice counseling vendor provides information about each MMA plan's coverage in accordance with federal requirements. Additional MMA plan information includes, but is not limited to: benefits and benefit limitations, cost-sharing requirements, provider

network information, and contact information. The Agency posts performance information including recipient satisfaction survey results and performance measure data (as data is available) on its Web site.

The choice counseling vendor provides recipients who have been auto-assigned into a plan with written information about their MMA plan assignment and information about the choice of MMA plans in their region (in the event the recipient wishes to change plans).

Once the enrollment is effective, the choice counseling vendor mails a welcome letter, a packet of information about the MMA plans available in the enrollee's region, accessing choice counseling services, and their right to change MMA plans.

3. General Enrollment Requirement

Mandatory recipients are enrolled in an MMA plan once their Medicaid enrollment determination is complete. Mandatory recipients are afforded the opportunity to choose an MMA plan. However, if the recipient does not select an MMA plan, the recipient will be auto-assigned to an MMA plan.

Voluntary recipients are enrolled in an MMA plan upon making a plan selection.

4. Auto-Assignment/Enrollment Criteria:

a. General Provisions

At a minimum, the Agency uses the following criteria when auto-assigning a recipient to an MMA plan:

- Whether the MMA plan has sufficient provider network capacity to meet the needs of the recipient.
- Whether the recipient has previously received services from one of the MMA plan's primary care providers.
- Whether primary care providers in one MMA plan are more geographically accessible to the recipient's residence than those in other MMA plans.

b. Special Populations

The Agency uses the following parameters when auto-assigning the following special populations to an MMA plan:

- Recipients Enrolled in a Medicare Advantage Plan

To promote alignment between Florida Medicaid and Medicare, each recipient who is enrolled in a Medicare Advantage Plan is assigned to any MMA plan in the recipient's region that is operated by the same parent organization as the recipient's Medicare Advantage Plan.

- Newborns

Newborns of mothers who are enrolled in a plan at the time of the child's birth are automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 120-days after enrollment. If the mother is enrolled in a specialty plan, the newborn must also meet the specialty plan eligibility criteria before being assigned into the specialty plan.

- Children in Foster Care
Children in foster care are assigned/re-assigned to the same primary care physician to which the child was most recently assigned in the last 12 months, if applicable.
- Recipients Meeting the Criteria for Enrollment in a Specialty Plan
Recipients who meet the eligibility criteria for a specialty plan in their region are assigned to the specialty plan.

5. Re-enrollment

In instances of a temporary (six month or less) loss of Florida Medicaid eligibility, the Agency re-enrolls recipients in the same MMA plan they were enrolled in prior to the loss of eligibility unless enrollment into the MMA plan has been suspended.

6. Lock-In/Disenrollment

Enrollees maintain their enrollment in their selected, or assigned, MMA plan for a total of 12 months until the next open enrollment period, unless:

- The enrollee is determined ineligible for Florida Medicaid.
- The enrollee requests to be voluntarily dis-enrolled from the MMA plan (without cause) during the 120 days following the date of the enrollee's initial enrollment in the plan. Mandatory enrollees are required to choose another MMA plan in their region.
- The enrollee submits a request for dis-enrollment (for cause). Good cause reasons for disenrollment from an MMA plan are specified in Rule 59G-8.600, Florida Administrative Code.

Voluntary enrollees may dis-enroll from their MMA plan at any time.

C. Benefits and Cost-Sharing

1. Standard Benefit Packages

- a. Managed Medical Assistance plans are required to provide the following services:

| Table 3 MMA Required Services |
|---|
| Advanced Registered Nurse Practitioner Services |
| Ambulatory Surgical Center Services |
| Assistive Care Services |
| Behavioral Health Services |
| Birth Center and Licensed Midwife Services |
| Clinic Services |
| Chiropractic Services |
| Dental Services |
| Child Health Check-Up |
| Immunizations |
| Emergency Services |
| Emergency Behavioral Health Services |
| Family Planning Services and Supplies |
| Healthy Start Services |
| Hearing Services |
| Home Health Services and Nursing Care |
| Hospice Services |
| Hospital Services |
| Laboratory and Imaging Services |
| Medical Supplies, Equipment, Protheses and Orthoses |
| Optometric and Vision Services |
| Physician Assistant Services |
| Podiatric Services |
| Practitioner Services |
| Prescribed Drug Services |
| Renal Dialysis Services |
| Therapy Services |
| Transportation Services |

- b. Managed Medical Assistance plans must ensure the provision of services in sufficient amount, duration, and scope to be reasonably expected to achieve the purpose for which the services are furnished.
- c. Managed Medical Assistance plans must use the Agency's definition of medical necessity (as defined in Rule 59G-1.010, Florida Administrative Code) when authorizing covered services.
- d. Managed Medical Assistance plans must comply with federal Early and Periodic Screening, Diagnosis, and Treatment requirements of 42 U.S.C. § 1396d(r)(5). As such, MMA plans must, for enrollees under the age of 21 years, pay for any "other necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services

are covered under the State Plan.” Managed Medical Assistance plans may not place any time caps (e.g., hourly limits, daily limits, or annual limits) or expenditure caps on services for enrollees under the age of 21 years.

2. Customized Benefit Packages

Managed Medical Assistance plans have the flexibility to provide customized benefit packages for non-pregnant adult enrollees. Customized benefit packages must include all mandatory State Plan services. MMA plans may vary the amount, duration and scope of optional State Plan services to reflect the needs of the MMA plan’s target population, and may offer additional services and benefits not available under the State Plan.

Customized benefit packages must be at least actuarially equivalent to the services provided to the target population under the current State Plan, meet a sufficiency test to ensure it meets the medical needs of the target population, and be prior-approved by the Agency and CMS.

Managed Medical Assistance plans are not currently offering customized benefit packages.

3. Expanded Benefits

Managed Medical Assistance plans may offer expanded benefits to enrollees as approved by the Agency.

Expanded benefits are services the MMA plan offers to all enrollees in specific population groups for which the MMA plan receives no direct payment from the Agency. Expanded benefits include services that the MMA plans are not required to cover, or that are in excess of the amount, duration, and scope specified in the State Plan.

For a list of list of expanded benefits currently offered by the MMA plans, as approved by the Agency, see Attachment II.

4. Cost Sharing

The Agency must pre-approve all cost-sharing (premiums and copayments) required by MMA plans from enrollees. Managed Medical Assistance plans may not exceed the cost-sharing amounts specified in the State Plan for covered services. Most MMA plans, as part of their expanded benefit package, have eliminated cost-sharing requirements.

D. Recipient Information/Enrollee Materials

The Agency provides information in accordance with section 1932(a)(5) of the SSA and 42 CFR 438.10, Information Requirements.

The MMA plans are required to provide enrollee information in accordance with 42 CFR 438.10, including:

- All enrollee communications, including written materials, spoken scripts and websites are at, or near, the fourth grade comprehension level.
- Written materials are available in English, Spanish, and all other appropriate foreign languages.

- Written materials are available in alternative formats and in a manner that takes into consideration the enrollee's special needs, including those who are visually impaired or have limited reading proficiency.

The MMA plans are required to make available (in print and online) a member handbook that provides information about the enrollees' rights and responsibilities, the role of primary care physicians, how to obtain care, what to do in an emergency or urgent medical situation, how to pursue a complaint, a grievance, appeal or Medicaid Fair Hearing, how to report suspected fraud and abuse, how to report abuse, neglect and exploitation, and all other requirements and benefits of the plan.

E. Eligible Plans

1. Eligible Plan Criteria

Services provided through the MMA program must be provided by eligible managed care plans. Eligible plans include:

- A health insurer authorized under Chapter 624, F.S.
- An exclusive provider organization authorized under Chapter 627 F.S.
- A health maintenance organization authorized under Chapter 641, F.S.
- A provider service network authorized under section 409.912(2), F.S. or an accountable care organization authorized under federal law. For purposes of the MMA program, the term also includes:
 - The Children's Medical Services plan authorized under Chapter 391, F.S.
 - Entities qualified under 42 CFR 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, Medicare Advantage Health Maintenance Organizations, Medicare Advantage Coordinated Care Plans, and Medicare Advantage Special Needs Plans, and the Program of All-inclusive Care for the Elderly.

2. Competitive Procurement

Florida law requires the Agency to contract with MMA plans through a competitive procurement process using, at a minimum, the following criteria in the selection process:

- Accreditation by a nationally recognized accrediting body
- Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations
- Availability and accessibility of primary care and specialty physicians in the provider network
- Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services
- Commitment to quality improvement
- Provision of additional benefits, particularly dental care and disease management and other initiatives that improve health outcomes

- Documentation of policies for preventing fraud and abuse

3. Plans per Region

Table 4 provides the minimum and maximum number of MMA plans that may provide services in each region.

| Table 4 MMA Plans Per Region | | | |
|---|-----------------------|-----------------------|----------------------------------|
| | Min # of Plans | Max # of Plans | Min # of PSNs² |
| Region 1 | 2 | 2 | 1 |
| Region 2 | 2 | 2 | 1 |
| Region 3 | 3 | 5 | 1 |
| Region 4 | 3 | 5 | 1 |
| Region 5 | 2 | 4 | 1 |
| Region 6 | 4 | 7 | 1 |
| Region 7 | 3 | 6 | 1 |
| Region 8 | 2 | 4 | 1 |
| Region 9 | 2 | 4 | 1 |
| Region 10 | 2 | 4 | 1 |
| Region 11 | 5 | 10 | 1 |

For a list of counties by region, see Attachment III. For a list of plans currently contracted to provide services under the MMA program, see Attachment IV.

The Agency imposes penalties for MMA plans that leave a region before the end of the contract term. Specifically, MMA plans are required to reimburse the Agency for the cost of enrollment changes and other transition activities associated with the MMA plan action. Managed Medical Assistance plans are required to provide at least 180 days' notice to the Agency before withdrawing from a region. If a contracted MMA plan leaves a region before the end of the contract term, the Agency is required by law to terminate all contracts with that MMA plan in other regions.

4. Re-procurement of Plans

During the 2017-2020 MMA Waiver extension period, the Agency will release an Invitation to Negotiate to solicit managed care plans that are qualified to provide required services under the MMA program.

F. Reimbursement

Capitation rates for the MMA plans are developed in accordance with 42 CFR 438.6. The Agency develops actuarially sound, risk-adjusted premiums by assessing historical Florida Medicaid expenditures and encounter data.

Health-based risk adjusters use individuals' historical diagnoses to predict expected future expenditures more effectively than age and gender. The purpose of health-based risk adjustment is to provide a risk score for each individual to reflect predicted health

² The PSN counts toward the minimum number of plans per region.

care needs. The scores of all of the recipients enrolled in each MMA plan determine the collective risk score and the resulting premiums for that MMA plan.

CMS reviews and approves all capitation rates in accordance with 42 CFR 438, insofar as the requirement is applicable.

G. Provider Network and Access Requirements

The Agency requires MMA plans to ensure availability of services in accordance with section 1932(c)(1)(A)(i) of the SSA and 42 CFR 438.206. MMA plans are required to have provider networks sufficient to meet the needs of the anticipated enrolled population and expected service utilization.

The Agency has established specific standards for the number, type, and regional distribution of providers in MMA plan networks. The MMA plans:

- Must maintain a panel of preventive and specialty care providers sufficient in number, mix and geographic distribution to meet the needs of the enrolled population.
- Are required to maintain a provider network sufficient to serve a percentage of recipients in the region, as established by the Agency, such that if any one MMA plan leaves a region, the remaining MMA plans have immediate capacity in the provider network (primary care and specialists) to serve all recipients in that region.
- Are required to have providers available within travel and distance standards established by the Agency.

The MMA plans may limit the providers in their network if network adequacy standards are met, but must include statewide essential providers in accordance with section 409.975, F.S.

The Agency may authorize MMA plans to include providers located outside of the contracted region, if appropriate, to meet time and distance or other network adequacy requirements standards.

MMA plans are required to establish and maintain an accurate and complete electronic database of contracted providers that is accessible to the public and allows comparison of the availability of providers to network adequacy standards. The plans must also report to the Agency weekly their updated network.

H. Grievance and Appeals³

The Agency requires each MMA plan have an approved internal grievance system that is consistent with federal law and allows a recipient, or a provider on behalf of a recipient, to challenge the denial of coverage of, or payment for, services as required by section 1932(b)(4) of the SSA and 42 CFR 438 Subpart H and Subpart F, Grievance System, insofar as these regulations are applicable.

The Agency requires each MMA plan to provide recipients with access to the Florida Medicaid fair hearing process as required under 42 CFR 431 Subpart E.

³ The State will amend the SMMC contracts in February 2017 to comply with the requirements of the CMS final rule.

I. Program Integrity

The Agency requires each MMA plan to comply with section 1932(d)(1) of the SSA and 42 CFR 438.610, Prohibited Affiliations with Individuals Barred by Federal Agencies.

Managed Medical Assistance plans must comply with 42 CFR 438.608, Program Integrity Requirements, insofar as these regulations are applicable. The Agency exercises administrative authority over the MMA program to prevent:

- Fraud or abuse
- Over-utilization/underutilization or duplicative utilization
- Inappropriate denial of services
- Enrollee abuse, neglect, or exploitation

The Agency refers suspected incidents to the appropriate regulatory agency, including the licensing authority and the Medicaid Fraud Control Unit in the Attorney General's office.

IV. Budget Neutrality

A. Budget Neutrality Compliance

The Agency is required to provide financial data demonstrating the detailed and aggregate, historical, and project budget neutrality status for the requested waiver extension period (July 1, 2017 to June 30, 2020), and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the CMS financial management standard questions. The following addresses the items specified above and documents the waiver is budget neutral.

1. **General Budget Neutrality Requirements:** 1115 Research and Demonstration Waiver programs must meet a budget neutrality test and provide documentation the demonstration did not cost the program more than would have been experienced without the waiver. In addition, prior to an extension of the waiver, a projection and extension of new budget neutrality benchmarks using rebased trends must be provided for the requested waiver extension period.

The established STCs for the MMA program, as agreed upon by the State and CMS, are provided in the approved waiver document. To comply with the STCs, the Agency must pass the budget neutrality “test” and provide quarterly reporting of the expenditures and member months for the waiver, which is used to monitor the budget neutrality. Florida’s 1115 MMA Waiver is budget neutral and is in compliance with all STCs specific to budget neutrality.

2. **Budget Neutrality Results to Date:** Table 5 provides cumulative expenditures and case months for the reporting period for each demonstration year (DY). The combined Per Capita Cost per Month (PCCM) is calculated by weighting Medicaid Eligibility Groups (MEGs) 1 and 2 using the actual case months. In addition, the PCCM targets, as provided in the STCs, are also weighted using the actual case months.

Since inception of the demonstration through DY 10, expenditures have been \$22.8 billion less than the authorized budget neutrality limit. As a result, the State is in substantial compliance with budget neutrality and anticipates that by the end of the demonstration, the amount below the authorized budget neutrality limit will be even greater. Details for each demonstration year are provided on the following page.

**Table 5
MEG 1 and 2 Cumulative Statistics**

| DY 01 | Actual CM | MEG 1 & 2 Actual Spend MCW & Reform Enrolled | | Total | PCCM |
|------------|------------|---|-----------------|-------------------|----------|
| Meg 1 & 2 | 18,141,234 | \$4,925,222,579 | \$399,716,255 | \$5,324,938,833 | \$293.53 |
| WOW | 18,141,234 | | | \$5,850,569,502 | \$322.50 |
| Difference | | | | \$(525,630,669) | |
| % Of WOW | | | | | 91.02% |
| DY 02 | Actual CM | MEG 1 & 2 Actual Spend MCW & Reform Enrolled | | Total | PCCM |
| Meg 1 & 2 | 17,863,960 | \$4,909,251,774 | \$710,757,766 | \$5,620,009,540 | \$314.60 |
| WOW | 17,863,960 | | | \$6,303,850,956 | \$352.88 |
| Difference | | | | \$(683,841,416) | |
| % Of WOW | | | | | 89.15% |
| DY 03 | Actual CM | MEG 1 & 2 Actual Spend MCW & Reform Enrolled | | Total | PCCM |
| Meg 1 & 2 | 20,344,582 | \$5,509,817,851 | \$782,189,441 | \$6,292,007,292 | \$309.25 |
| WOW | 20,344,582 | | | \$7,574,019,350 | \$372.29 |
| Difference | | | | \$(1,282,012,059) | |
| % Of WOW | | | | | 83.07% |
| DY 04 | Actual CM | MEG 1 & 2 Actual Spend MCW & Reform Enrolled | | Total | PCCM |
| Meg 1 & 2 | 23,390,983 | \$6,058,520,103 | \$902,006,202 | \$6,960,526,306 | \$297.57 |
| WOW | 23,390,983 | | | \$9,046,759,079 | \$386.76 |
| Difference | | | | \$(2,086,232,774) | |
| % Of WOW | | | | | 76.94% |
| DY 05 | Actual CM | MEG 1 & 2 Actual Spend MCW & Reform Enrolled | | Total | PCCM |
| Meg 1 & 2 | 25,185,957 | \$6,473,151,442 | \$988,601,293 | \$7,461,752,734 | \$296.27 |
| WOW | 25,185,957 | | | \$10,402,975,168 | \$413.05 |
| Difference | | | | \$(2,941,222,434) | |
| % Of WOW | | | | | 71.73% |
| DY 6 | Actual CM | MEG 1 & 2 Actual Spend MCW & Reform Enrolled | | Total | PCCM |
| Meg 1 & 2 | 26,610,064 | \$6,929,318,089 | \$1,148,641,394 | \$8,077,959,483 | \$303.57 |
| WOW | 26,610,064 | | | \$11,517,211,082 | \$432.81 |
| Difference | | | | \$(3,447,220,239) | |
| % Of WOW | | | | | 70.14% |
| DY 7 | Actual CM | MEG 1 & 2 Actual Spend MCW & Reform Enrolled | | Total | PCCM |
| Meg 1 & 2 | 28,179,336 | \$7,224,274,901 | \$1,406,961,008 | \$8,631,235,909 | \$306.30 |
| WOW | 28,179,336 | | | \$12,789,222,314 | \$453.85 |
| Difference | | | | \$(4,157,986,405) | |
| % Of WOW | | | | | 67.49% |
| DY 08 | Actual CM | MEG 1 & 2 Actual Spend MCW & Reform Enrolled | | Total | PCCM |
| Meg 1 & 2 | 28,867,69 | \$7,198,209,036 | \$1,579,606,142 | \$8,777,815,179 | \$304.07 |
| WOW | 28,867,69 | | | \$13,874,528,641 | \$480.62 |
| Difference | | | | \$(5,096,713,462) | |
| % Of WOW | | | | | 63.27% |

B. Financial Management Standard Questions

1. **Question:** Section 1903(a) (1) of the SSA, provides that federal matching funds are only available for expenditures made by states for services under the approved State Plan. Do providers receive and retain the total Florida Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Response: Providers retain 100 percent of all payments made relating to the MMA program. If an error occurs and payments are returned to the State, the State will track and report appropriately. The federal share is calculated and returned to CMS by making adjustments on the quarterly CMS 64 report.

2. **Question:** Section 1902(a) (2) of the SSA, provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the State share of each type of Florida Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the State share is from appropriations from the legislature to the Florida Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide State share. Note that, if the appropriation is not to the Florida Medicaid agency, the source of the State share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the State agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
 - (i) a complete list of the names of entities transferring or certifying funds;
 - (ii) the operational nature of the entity (State, county, city, other);
 - (iii) the total amounts transferred or certified by each entity;
 - (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
 - (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: There are no intergovernmental transfers or certified public expenditures directly related to the payments for the MMA program. The State share of payments for the MMA program is appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund, and the Provider Medical Assistance Trust Fund.

3. **Question:** Section 1902(a) (30) requires that payments for services be consistent with efficiency, economy and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response: There are no supplemental or enhanced payments being made for the MMA program.

4. **Question:** Please provide a detailed description of the methodology used by the State to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated and privately owned or operated). Please provide a current (i.e. applicable to current rate year) UPL demonstration.

Response: On March 18, 2013, Federal CMS issued a State Medicaid Director's Letter (SMDL #13-003) describing the mutual federal and state obligations and accountability on the part of the state and federal governments for the integrity of the Medicaid program. Among the obligations included: ongoing consistency with the applicable federal upper payment limit (UPL) requirements described in regulation for certain services. The regulations implement, in part, section 1902(a)(30)(A) of the Social Security Act which requires that Medicaid rates are consistent with efficiency, economy and quality of care. Starting in 2013, states are required to submit UPL demonstrations on an annual basis. Previously this information was collected or updated only when a state was proposing an amendment to a reimbursement methodology in its Medicaid state plan. Beginning in 2013, states must submit UPL demonstrations for inpatient hospital services, outpatient hospital services and nursing facilities.

For Florida State Fiscal Year (SFY) 2015-16, the UPL analysis involves estimating Medicare payment for a set of Medicaid claims and comparing those payments to actual payments made by Medicaid. The claim data and hospital Medicare cost data are aligned so that they are from the same time frame. In addition, inflation factors are applied as appropriate to make payment and cost amounts comparable under the same time frame. Also if appropriate, other adjustments may be made to the baseline claim data to align with Medicaid program changes that have occurred between the timeframe of the baseline claim data and the UPL rate year.

Comparisons of Medicaid payments to estimated Medicare payments (the UPLs) are made separately for hospital inpatient and outpatient services. Also, the comparisons are made for three categories of providers: (1) state owned (2) non-state government owned; and (3) privately owned hospitals.

A UPL analysis has been completed to accompany both the SFY 2015-16 inpatient and outpatient reimbursement state plan amendments.

Estimated Medicare payments which determine the UPL were calculated using a detailed costing method. For each hospital, information extracted from Medicare

cost reports were used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. In addition, a mapping of revenue codes to cost centers was created. This mapping allowed a cost center to be identified for each claim detail line based on the revenue code submitted on the line. Costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. Total costs on all claim lines for a provider were summed to get the UPL amount per provider and then summed by category of provider to get the UPL amount for the three UPL categories: state-owned, non-state government owned, and privately owned (all others).

The UPL for each of the three UPL categories was calculated using the detailed costing demonstration method. For each hospital, information extracted from Medicare cost reports was used to calculate cost-based per diems for each routine cost center and cost-to-charge ratios for each ancillary cost center. Standard cost centers as defined by CMS were used. In addition, a mapping was created to assign revenue codes to cost centers. This allowed each claim detail line item to be assigned a cost center. Hospital costs on detail lines that mapped to routine cost centers were calculated by multiplying the cost center's cost per diem times the number of applicable days indicated on the line. Hospital costs on detail lines that mapped to ancillary cost centers were calculated by multiplying the charges on the line by the cost center's cost-to-charge ratio. The hospital cost amounts on all the claim lines for a hospital were summed to get the total cost for the hospital, and total hospital cost was used as the upper payment limit.

5. **Question:** Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to Federal CMS on the quarterly expenditure report?

Response: Payments to providers relating to this program will not exceed, in the aggregate, reasonable costs of providing services. If payments do exceed reasonable cost of providing services, the provider must return the excess amount to the State. Once the State has received the returned funds, appropriate documentation is made and the federal share is calculated and returned to CMS. The excess is returned to the State and the federal share is reported on the 64 report to CMS.

V. Quality Initiatives

This section provides summaries of the External Quality Review Organization reports, State quality assurance monitoring, and other documentation of the quality of, and access to, care provided under the MMA program in compliance with 42 CFR 431.412 and the approved STCs.

A. External Quality Review Organization (EQRO) Activities

1. External Quality Review Activities

The Agency contracts with Health Services Advisory Group, Inc. (HSAG) as its EQRO vendor. The State's EQRO, in compliance with section 1932(c)(2) of the SSA and 42 CFR 438 subpart E, conducts an annual, independent, external quality review of the outcomes and timeliness of, and access to, the services delivered under each MMA plan contract in Florida.

The EQRO currently conducts the following activities:

- Validates performance improvement projects (PIP)
- Validates performance measures
- Reviews compliance with access, structural and operational standards
- Validates of encounter data
- Focused studies
- Education and training
- Annual technical report
- Technical assistance on other activities

2. Validating Quality Initiatives

a. Validating PIPs

The MMA plans must perform four Agency approved PIPs to improve the quality of health care in targeted areas. The plans are required to conduct PIPs on prenatal/postpartum care, well-child visits within the first 15 months of life, and child preventive dental visits. The MMA plans are required to submit the PIPs to the Agency and the EQRO vendor each year. The EQRO also evaluates the PIPs' implementation to determine how well the MMA plan has improved its rates on the targeted performance measures. The EQRO reviewed the PIP designs in the fall/winter of 2014-2015 and the baseline reporting in the fall of 2015. The first re-measurement reporting will be reviewed in the fall of 2016.

b. Validating Performance Measures

The MMA plans must report on a specific set of Agency-defined measures. The EQRO reviews and validates the audit findings from each MMA plan's final audit report produced by the licensed auditing organization. For calendar year 2014 data, the EQRO determined the data collected and reported for the measures selected by the Agency followed the appropriate methodology. Therefore, any rates and audit designations were determined to be valid, reliable and accurate. The EQRO will conduct performance measure validation activities for calendar year 2015 during the fall of 2016.

c. Validating Network Adequacy

In 2015, the Agency requested the EQRO conduct a targeted network adequacy review of hospitals in the MMA program. This was completed in two phases:

- Phase 1 compared network data from each of the MMA plans to the Agency licensure data and identified discrepancies in each MMA plan's network data.
- Phase 2 compared the calendar year 2016 Medicare advantage health services delivery reference file standards to the Agency's urban/rural network standards and identified the differences in the two sets of standards.

These EQRO reviews concluded the MMA plans were in compliance with the acute care hospital bed ratio, and the Agency's minimum performance standards for travel time and distance are generally more stringent than the performance standards for travel time and distance required for Medicare managed care plans.

d. Validating Encounter Data

The Agency selects targeted service areas to be examined, and the EQRO reviews the encounter data along with the associated medical records.

- During State Fiscal Year 2013-2014, the EQRO conducted an assessment of the MMA plans' and the Agency's information systems.
- During State Fiscal Year 2014-2015, the EQRO conducted a review of encounter data for dates of services from January 1, 2013 through March 31, 2014, for professional, dental, and institutional encounters.
- During State Fiscal Year 2015-2016, the EQRO conducted a review of encounter data for dates of services from January 1, 2015 through June 30, 2015, for dental and therapy encounters.

The EQRO is in the process of finalizing the State Fiscal Year 2015-2016 report and will submit the report to the Agency in the fall of 2016. The EQRO found the encounters submitted by the MMA plans were generally supported by the medical records.

B. Plan Performance Measures

1. Performance Measure Requirements

Quality is a primary focus of the MMA program. The Agency has specific performance measures for which the MMA plans are required to submit data. These performance measures are in place to monitor health care service delivery and to provide a mechanism for assessing the effectiveness of the program. The Agency reviewed the following quality performance measure sets to ensure the Agency required measures in the MMA contract were broadly applicable across the enrolled population, scientifically sound or evidence-based, measurable, and actionable:

- Health Plan Effectiveness Data and Information Set (HEDIS) measures
- CMS core set of children's health care quality measures for Medicaid and Children's Health Insurance Program (child core set)
- CMS core set of adult health care quality measures for Medicaid (adult core set)

Over the past two years, the Agency has made several changes to the required performance measures. These changes were due to modifications to HEDIS by the National Committee for Quality Assurance and changes to CMS's child core set and corresponding adult core set. The Agency has selected standardized national measures as much as possible, but has retained several Agency-defined measures when there were no comparable national measures for key areas of health outcomes.

The Agency has also added several of the CMS Medicaid adult core set measures to the reporting requirements for the MMA plans (e.g., annual monitoring for patients on persistent medications, hospital readmissions, and initiation and engagement of alcohol and other drug dependence treatment).

The Agency continues to review the performance measures reported by the MMA plans and consider changes. As national, standardized measures are developed that can replace Agency-defined measures, the Agency will adopt those measures in order to collect data that can be compared to other states and national benchmarks. As measures are added and removed from the child and adult core sets, and as technical specifications for these measures become available, the Agency will work on including these measures in required reporting.

MMA plans that perform highly on HEDIS® performance measures compared to the NCQA national means and percentiles have the opportunity to earn financial incentives through an achieved savings rebate.

Table 6 provides the list of performance measures the MMA plans were required to report to the Agency on July 1, 2016, for calendar year 2015.

| Table 6 | | |
|---|---|---|
| Plan Performance Measures for Calendar Year 2015 | | |
| HEDIS | | Children's and/or Adult Core Set Measure |
| 1 | Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) | Yes |
| 2 | Adolescent Well Care Visits (AWC) | Yes |
| 3 | Adults' Access to Preventive /Ambulatory Health Services (AAP) | |
| 4 | Ambulatory Care (AMB) | Yes |
| 5 | Annual Dental Visit (ADV) | |
| 6 | Annual Monitoring for Patients on Persistent Medications (MPM) | Yes |
| 7 | Antidepressant Medication Management (AMM) | Yes |
| 8 | Adult Body Mass Index (BMI) Assessment (ABA) | Yes |
| 9 | Breast Cancer Screening (BCS) | Yes |
| 10 | Call Answer Timeliness (CAT) | |
| 11 | Cervical Cancer Screening (CCS) | Yes |
| 12 | Childhood Immunization Status (CIS) – Combo 2 and 3 | Yes |
| 13 | Children and Adolescents' Access to Primary Care Practitioners (CAP) | Yes |
| 14 | Chlamydia Screening in Women (CHL) | Yes |

| | | |
|---|---|-----|
| 15 | Comprehensive Diabetes Care (CDC) <ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c control (<8%) • Eye exam (retinal) performed • Medical attention for nephropathy | Yes |
| 16 | Controlling High Blood Pressure (CBP) | Yes |
| 17 | Follow-up Care for Children Prescribed ADHD Medication (ADD) | Yes |
| 18 | Frequency of Ongoing Prenatal Care (FPC) | Yes |
| 19 | Immunizations for Adolescents (IMA) | Yes |
| 20 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) | Yes |
| 21 | Lead Screening in Children (LSC) | |
| 22 | Medication Management for People with Asthma (MMA) | Yes |
| 23 | Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | |
| 24 | Prenatal and Postpartum Care (PPC) | Yes |
| 25 | Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) | Yes |
| 26 | Well-Child Visits in the First 15 Months of Life (W15) | Yes |
| 27 | Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) | Yes |
| Agency-defined Performance Measures | | |
| 28 | Follow-Up after Hospitalization for Mental Illness (FHM) | Yes |
| 29 | Highly Active Anti-Retroviral Treatment (HAART) | |
| 30 | HIV-Related Medical Visits (HIVV) | |
| 31 | Mental Health Readmission Rate (RER) | |
| 32 | Transportation Timeliness (TRT) | |
| 33 | Transportation Availability (TRA) | |
| Child Health Check-Up Report (CMS-416) | | |
| 34 | Dental Treatment Services (TDENT) | |
| 35 | Sealants (SEA) | |
| Child Core Set | | |
| 36 | Preventive Dental Services (PDENT) | Yes |
| 37 | Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL) | Yes |
| 38 | HPV Vaccine for Female Adolescents (HPV) | Yes |
| 39 | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC) | Yes |
| Adult Core Set | | |
| 40 | Antenatal Steroids (ANT) | Yes |
| 41 | Plan All-Cause Readmissions (PCR) | Yes |
| 42 | HIV Viral Load Suppression (VLS) | Yes |
| 43 | Medical Assistance with Smoking and Tobacco Use Cessation (MSC) | Yes |

*AMB is a utilization measure and has not been compared against a national benchmark.

2. Performance Measure Results

In analyzing the statewide average results for calendar years 2014 and 2015, the data demonstrates a steady upward trend for many of the performance measures. There are several measures where the calendar year 2015 statewide average results surpass the 75th percentile of Medicaid plans nationally, and three that surpass the 90th percentile.

For calendar year 2014, 33 of the 51 statewide weighted means were at, or better than, the national mean. For calendar year 2015, 25 of the 49 statewide weighted means were at, or better than, the national mean.

Of the 2015 statewide weighted means that were lower than the national mean, seven of them showed improvement over the 2014.

Performance measures with notable improvement include:

- Annual dental visit - total: The statewide weighted average increased from 34.3% in 2014 to 46.7% in 2015.
- Diabetes - nephropathy: The statewide weighted average increased from 84.1% in 2014 to 91.6% in 2015.
- Follow-up after hospitalization from illness – seven-day: The statewide weighted average increased from 24.4% in 2014 to 35.7% in 2015.
- Follow-up after hospitalization for mental illness – 30 day: The statewide weighted average increased from 38.0% in 2014 to 42.5% in 2015.

For a complete list of the statewide average results for performance measures submitted for calendar years 2014 and 2015 compared to their respective national means, see Attachment V.

C. Recipient Satisfaction Surveys

The MMA plans are required to contract with a certified survey vendor to conduct the Consumer Assessment of Health Plan Satisfaction (CAHPS) survey each year. The surveys must be conducted according to the National Committee on Quality Assurance's (NCQA) mixed mode protocols, and MMA plans must conduct both an adult survey and a child survey. The MMA plans are required to report the certified results to the Agency annually. Beginning with the 2016 survey, MMA plans are also required to report the results to NCQA to be included in the national Medicaid means and percentiles. This will help ensure that the national data are more representative of the health care delivery system in Florida.

The results of these surveys are used to assess quality of, and experiences with, care provided by the MMA plans. These results are posted on the Agency's Florida Health Finder Web site so that recipients may use the survey results to compare plans when making enrollment decisions.

The CAHPS surveys were conducted in the spring of 2015 and the spring of 2016. Results for the two years are presented below. Note: The 2016 results are preliminary.

1. Rating of MMA Plan

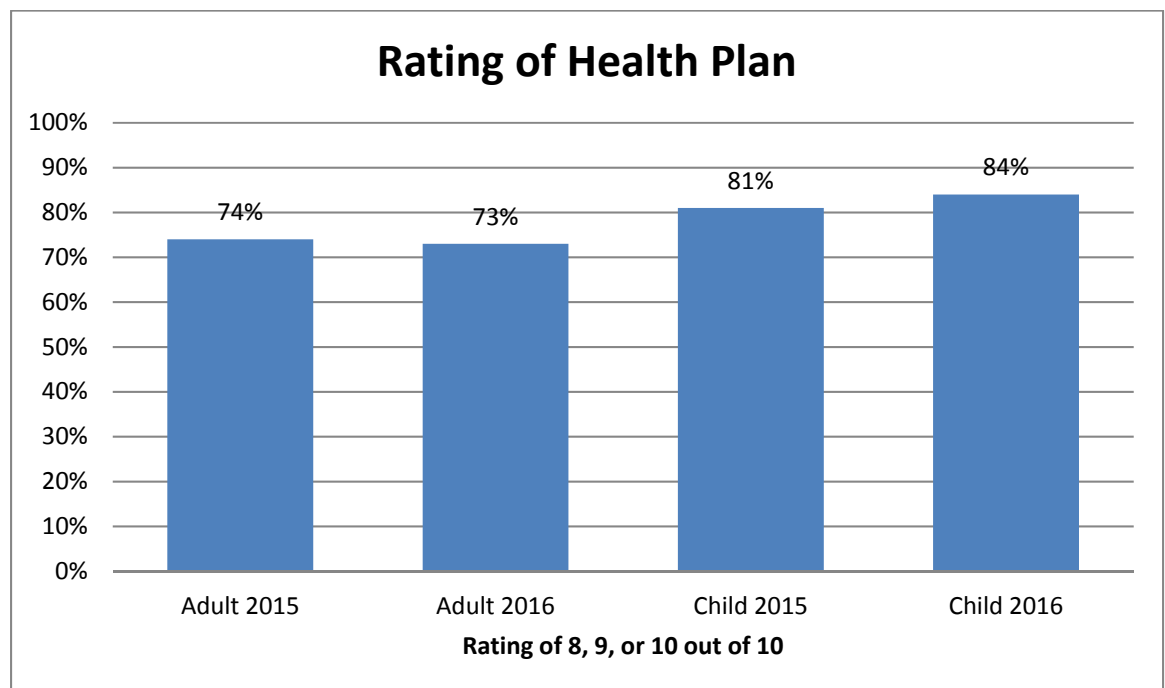
The CAHPS survey asked enrollees to rate their MMA plan on a scale from 0 to 10, with 0 being the worst plan possible and 10 being the best plan possible.

Adult's rating of their MMA plan:

- 2015: 74% of adults rated their MMA plan an 8, 9, or 10 out of 10
- 2016: 73% of adults rated their MMA plan an 8, 9, or 10.

Parent's rating of their child's MMA plan:

- 2015: 81% of parents rated their child's plan an 8, 9, or 10 out of 10
- 2016: 84% of parents rated their child's plan a rating of 8, 9 or 10.



2. Rating of Health Care

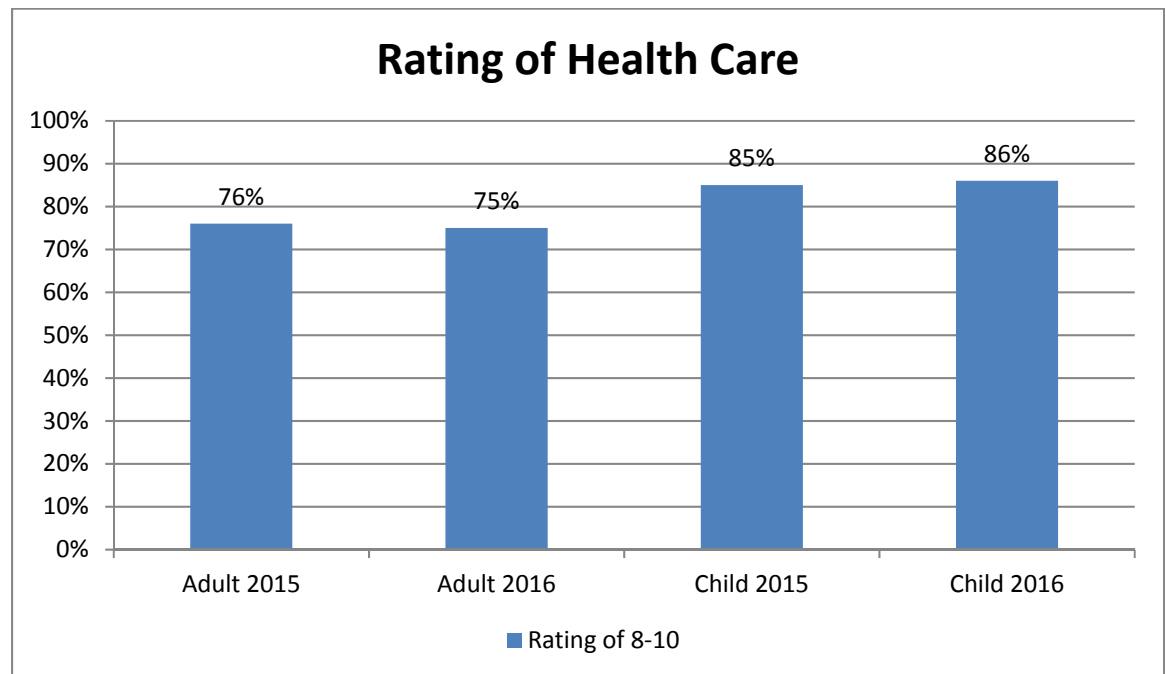
The CAHPS survey asked enrollees to rate their health care on a scale of 0 to 10, with 0 being the worst care possible, and 10 being the best health care possible.

Adult's rating of their health care:

- 2015: 76% of adults rated their health care an 8, 9 or 10
- 2016: 75% of adults rated their health care an 8, 9 or 10.

Parent's rating of their child's health care:

- 2015: 85% of parents rated their child's health care an 8, 9, or 10.
- 2016: 86% of parents gave their child's health care an 8, 9 or 10.



3. Getting Needed Care and Getting Care Quickly

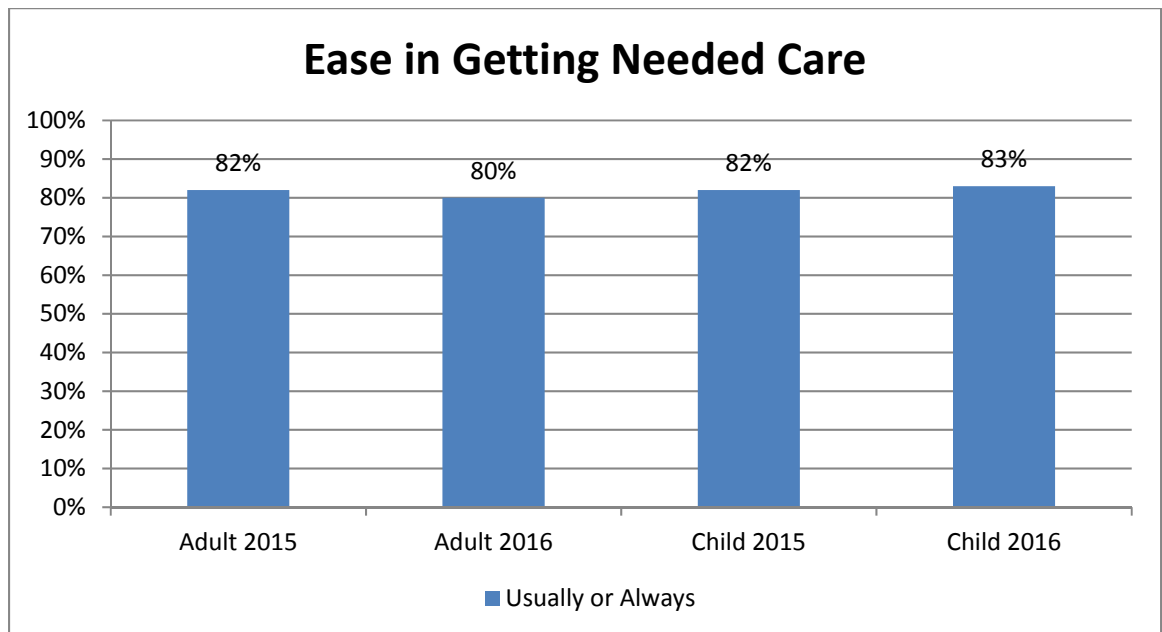
The CAHPS survey asked enrollees about the ease of obtaining specialist appointments and getting care, tests, or treatment they need through their MMA plan. These two survey items asked how often the enrollee got an appointment to see a specialist as soon as he/she needed, and how often it was easy to get the care, tests or treatment he/she needed. The response categories for these items are never, sometimes, usually, and always. A composite called “Ease in Getting Needed Care” averages the responses for these two survey items.

Adult’s rating of their ease of getting needed care:

- 2015: 82% of adults reported it was usually or always easy to get needed care.
- 2016: 80% of adults reported it was usually or always easy to get needed care.

Parent’s rating of their child’s ease of getting needed care:

- 2015: 82% of parents reported it was usually or always easy to get needed care for their child.
- 2016: 83% of parents reported it was usually or always easy to get needed care for their child.



4. Getting Care Quickly

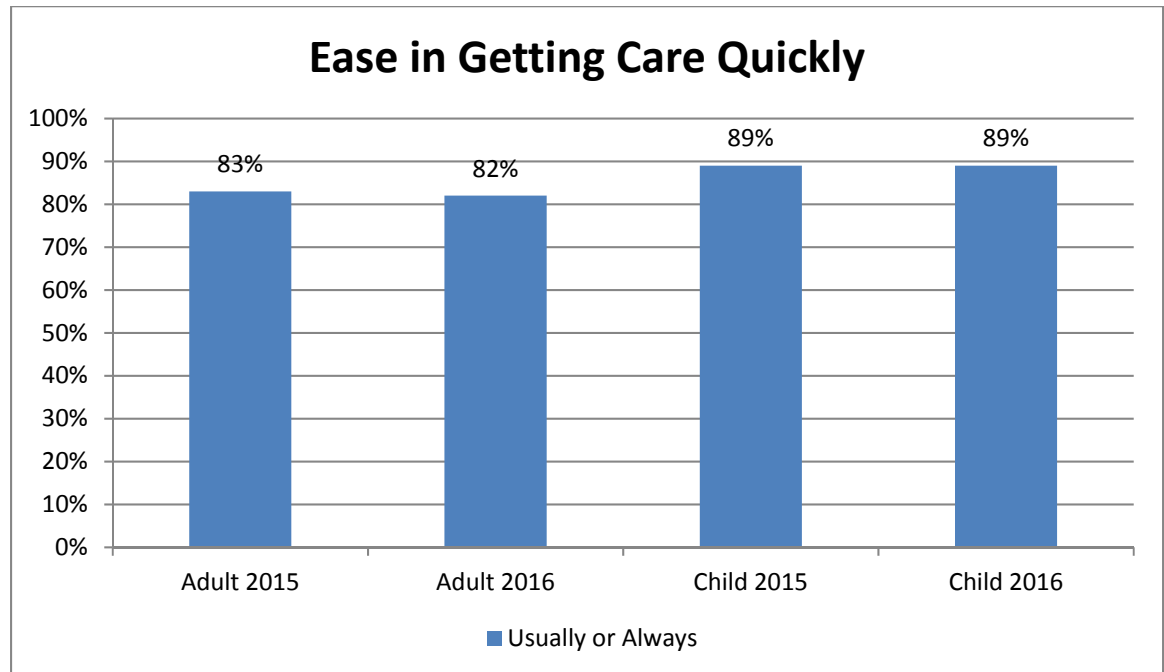
The CAHPS survey asked enrollees about how often they received care as soon as they needed it in both urgent and non-urgent/routine situations. The two survey items are averaged to make a composite score. The response categories for these items are never, sometimes, usually, and always.

Adult's rating of getting care quickly:

- 2015: 83% of adults reported that it was usually or always easy to get care as soon as they needed it 2016:
- 2016: 82% of adults reported that it was usually or always easy to get care as soon as they needed.

Parent's rating of getting care quickly:

- 2015 and 2016: 89% of parents reported that it was usually or always easy to get care as soon as their children needed it.



5. How Well Doctors Communicate

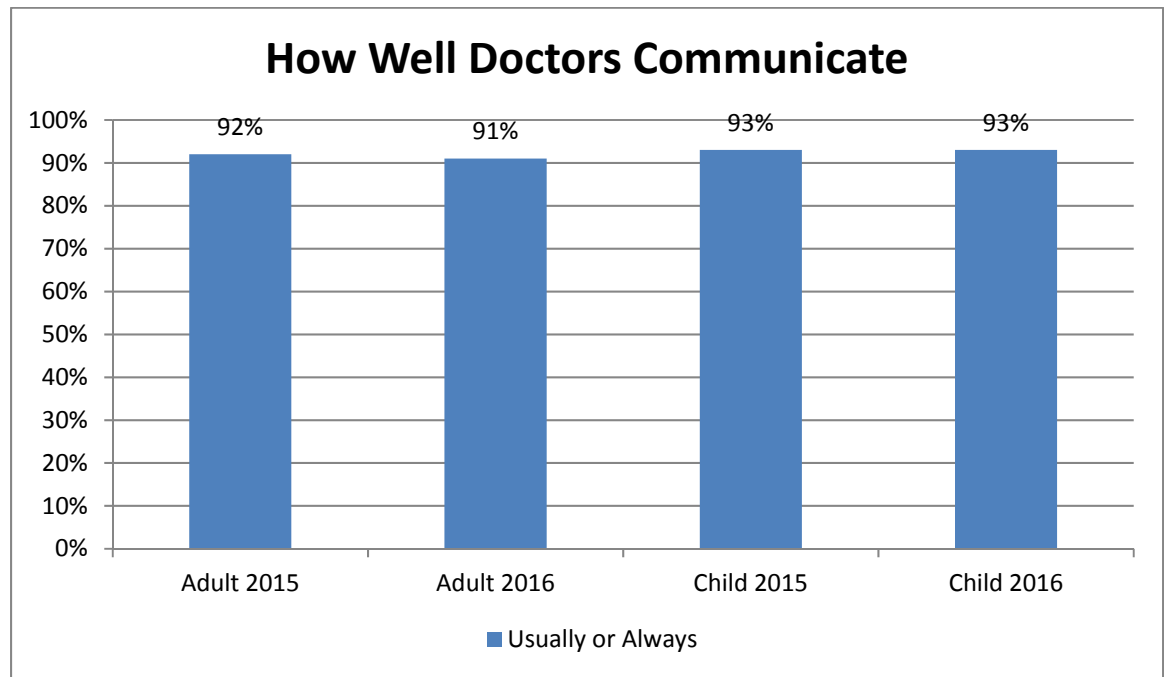
The CAHPS survey asked enrollees several questions regarding how often their personal doctor communicated well with them. These survey items ask how often the personal doctor: explained things in a way that was easy to understand; listened carefully to the respondent; showed respect for what the respondent had to say; and spent enough time with the respondent. The response categories for these items are never, sometimes, usually, and always. The four item responses are averaged into a composite score that is labeled as “How Well Doctors Communicate.”

Adult’s rating of how well Doctors communicate:

- 2015: 92% of adults reported their doctors usually or always communicated well.
- 2016: 91% of adults reported their doctors usually or always communicated well

Parent’s rating of how well Doctors communicate:

- 2015 and 2016: 93% of parents reported their child’s doctors usually or always communicated well.



6. Getting Help from Customer Service

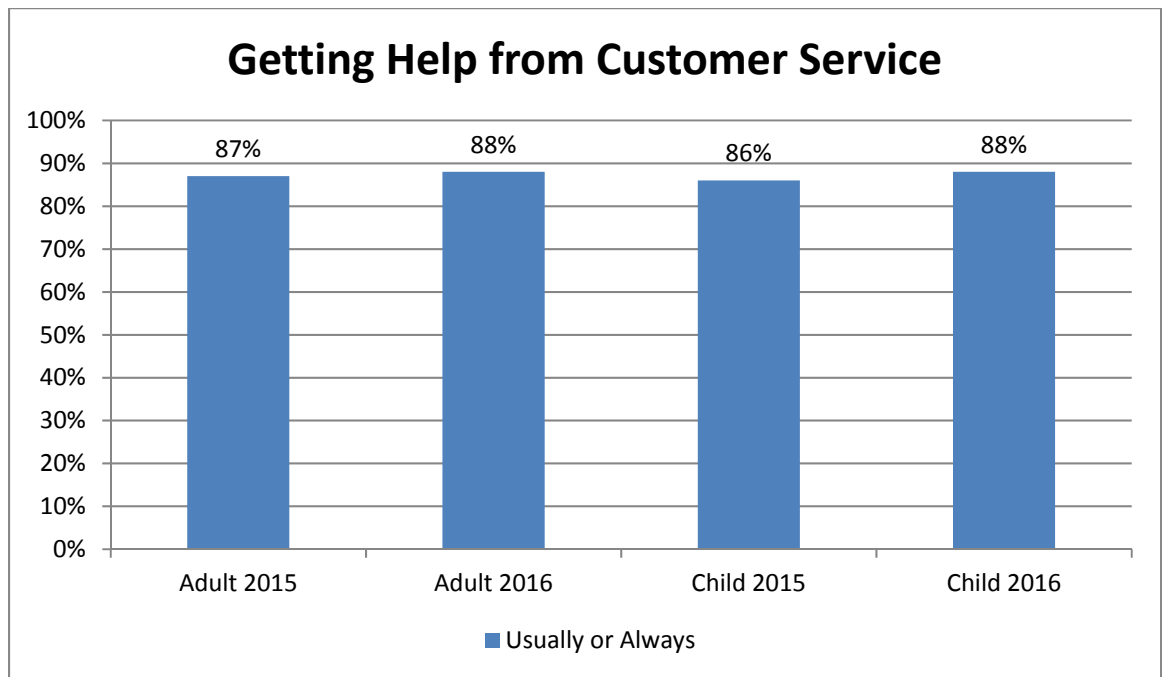
The CAHPS survey asked enrollees how often their MMA's plan's customer service gave them the information or help they needed, and how often the customer service staff treated them with courtesy and respect. The response categories for these two items are never, sometimes, usually, and always. The responses to the two items are averaged into one composite score.

Adult's rating of customer service:

- 2015: 87% of adults reported they usually or always received the information and help they needed from their MMA plan's customer service.
- 2016: 88% of adults reported they usually or always received the information and help they needed from their MMA plan's customer service.

Parent's rating of their child's customer service:

- 2015: 86% of parents reported they usually or always received the information and help they needed from their child's MMA plan's customer service.
- 2016: 88% of parents reported they usually or always received the information and help they needed from their child's MMA plan's customer service.



D. CMS-416 Report

The CMS-416 report is due to CMS on April 1 of each year. To increase the accuracy of the report, the Agency worked with CMS to refine the Agency's data collection process to eliminate potential duplication of eligible recipients in the reported data by comparing fee-for-service claims and encounter data.

The MMA plans, by Agency contract and Florida law, must achieve a child health checkup screening rate of at least 80% for those enrollees who are continuously enrolled in the MMA plan for at least eight months. In addition, the MMA plans must achieve at least an 80% child health check-up screening participation rate. The MMA plans may be assessed liquidated damages if the child health check-up screening rate and/or participation rate fall below the 80% goal.

The Agency also added a child preventive dental services rate requirement of at least 28% to the MMA contract, with possible liquidated damages if an MMA plan did not meet the requirement in federal fiscal year 2014-15. Beginning with federal fiscal year 2015-2016 reporting, the Agency has added new targets for each preventive dental services and dental treatment services, with possible liquidated damages if an MMA plan does not meet each year's target rates.

The State's 2016 CMS4-16 report reflected 31% of eligible children enrolled for ninety continuous days received a preventive dental service. This is an increase of five percentage points from the previous reporting period and 13 percentage points from the federal fiscal year 2012 report. In addition, 139,641 children received a sealant on a permanent molar, versus the previous year's total of 102,599.

E. Additional Quality Activities

The EQRO devised the methodologies for the two mandated PIPs. The Agency and the EQRO have facilitated the provision of tools/resources aimed at assisting the plans in building stronger PIPs, particularly regarding interventions aimed at improving the utilization of preventive dental services.

In the spring of 2016, Agency staff began conducting quarterly PIP check-in meetings with the MMA plans individually, to discuss the plans' progress on its PIPs and the interventions they have tested. The first and second PIP check-in meetings with the MMA plans focused on the preventive dental services PIPs. The next quarterly meeting with the MMA plans and the next PIP check-in meetings, will focus on the prenatal care and well-child visits in the first 15 months of life PIPs.

VI. Program Oversight

A. Monitoring

The Agency oversees the MMA program utilizing a multi-prong monitoring approach that incorporates subject matter experts across the Agency to ensure MMA plans are in compliance with the contract. Such approaches include, but are not limited to, the use of strategically located staff who are readily available to conduct on-site visits to MMA plans and provide compliance oversight in the areas of provider claims and marketing.

Agency monitoring efforts occur weekly, monthly, quarterly, yearly, and on an ad-hoc basis. The approaches used include on-site visits to the MMA plans and reviews of monitoring reports and other program data and documents.

Areas monitored through these approaches include, but are not limited to:

- Financial solvency
- Claims processing
- Subcontractor and affiliates
- Fraud and abuse
- Case manager caseloads
- Timeliness of recipient assessments/services authorizations
- Member services
- Provision of child health check-ups
- Service coverage
- Timely access to services
- Critical incidents
- Denied/reduced/terminated or suspended services
- Recipient complaints, grievance, appeals/grievance system
- Care coordination
- Performance measures
- Performance improvement projects
- Marketing
- Provider complaints
- Provider network/provider terminations and additions
- Disease management program
- Business continuity-disaster recovery/emergency management plan
- Cultural competency plan
- Recipient satisfaction survey results and action plan

Actions taken as a result of Agency monitoring include liquidated damages, corrective action plans (CAPs), sanctions, or a combination of these. Each MMA plan has complied with the final actions issued, or is in the process of completely fulfilling the terms of the issued CAP.

1. Annual Review

MMA plans are required to submit documentation/reports of certain requirements prior to contract implementation, and annually thereafter, as directed by the Agency.

For example, MMA plans must submit a quality improvement plan within 30 days of initial contract execution and upon request. Upon submission, the MMA plan Quality Improvement Plan is reviewed against the required components in the contract. The Agency provides technical assistance as necessary to ensure each quality improvement plan meets the current contract requirements. The quality improvement plan review includes identifying action items. Each MMA plan's quality improvement plan has been reviewed and approved by the Agency.

The MMA plans are also required to submit a disease management program description as part of the readiness review process. By April 1st of each year, the MMA plans must submit an updated disease management description or an attestation stating no changes have been made to the disease management program. Upon submission, the MMA plan disease management program description is reviewed against the required components in the contract. The Agency provides technical assistance as necessary to ensure each disease management program description meets current contract requirements. All MMA plans have submitted updated disease management program descriptions or attestations in a timely manner and each description has been reviewed by the Agency to ensure contract compliance.

2. Readiness Review

The Agency conducts readiness reviews to ensure plans selected during a competitive procurement process are qualified and able to comply with the MMA plan contract.

Readiness reviews consist of desk and on-site assessments of the following contractual areas:

- Internal staffing plans/organizational charts
- Provider and recipient materials
- Enrollment and eligibility
- Recipient services
- Covered services
- Provider contracting
- Provider network adequacy by region (including dental)
- Provider network access, by travel time and distance
- Provider availability for routine, urgent and emergent appointments;
- Provider credentialing/recredentialing
- Provider services

- Quality assurance
- Utilization management
- Coordination and continuity of care
- Case management
- Grievance/appeals
- Administration and management
- Claims processing
- Encounter data processing
- Health information systems
- Program integrity

B. Penalties and Sanctions

The Agency imposes liquidated damages when an MMA plan breaches specified contract requirements including, but not limited to:

- Failure to provide continuity of care and a seamless transition consistent with services in place prior to the new recipient's enrollment in the MMA plan.
- Failure to timely complete a comprehensive assessment or timely develop a treatment or service plan or to authorize and initiate services.
- Failure to facilitate transfers between health care settings.
- Imposition of arbitrary utilization guidelines.
- Reporting requirements.
- Fraud and abuse compliance.
- Performance measures.
- Maintenance of required insolvency protection and surplus accounts at appropriate levels, submission of timely and audited financial statements.
- Failure to resolve problems with individual encounter records.
- Failure to obtain Agency approval of recipient and provider materials.
- Non-submission of performance improvement projects (PIPs).
- Compliance with community outreach and marketing requirements.
- Notice of action failures and other recipient notification failures, medical and behavioral health network adequacy failures.

The liquidated damages range from \$250 per occurrence (failure to certify reports correctly) to \$25,000 per occurrence (imposition of arbitrary utilization guidelines).

VII. Additional Programs

The Agency is requesting to continue to operate these additional program as authorized in the current STCs.

A. 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:

1. MomCare

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 dis-enroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources, family planning services, and Medicaid coverage for the infant and the need to select a primary care physician.

2. Healthy Start Coordinated System of Care

The 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 three 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.

B. Program for All Inclusive Care for Children (PACC)

Participation in the PACC program is voluntary. The PACC program provides the following pediatric palliative care support services to children enrolled in the Children's Medical Services plan who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider:

- Support Counseling
- Expressive Therapies
- Respite Support
- Hospice Nursing Services
- Personal Care
- Pain and Symptom Management

C. Comprehensive Hemophilia Disease Management Program

The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized service whereby all Florida Medicaid recipients who have a diagnosis of hemophilia or von Willebrand disease are required to obtain pharmaceutical services and products related to factor replacement therapy from the vendors contracted with the Agency. In addition to product distribution, the program provides for the following additional services at no cost to the State:

- Pharmacy benefit management
- Direct beneficiary contact
- Personalized education
- Enhanced monitoring
- Direct support of beneficiaries in the event of hospitalization

VIII. Evaluation Status and Findings

A. Overview of Independent Evaluation

The draft evaluation covers the period July 1, 2014 through June 30, 2017. The CMS-approved draft evaluation design builds and improves upon the previous evaluation design. The draft evaluation design includes 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 recipients, providers, plans, market areas and public expenditures. The design accommodates and reflects the staggered implementation of the MMA program to produce more reliable estimates of program impacts. The contract to conduct the evaluation is currently being executed.

B. Research Questions and Findings

The Agency intends to continue to use the approved evaluation questions, hypothesis, and analyses to study the domains.

At this time, no evaluation reports have been completed, and therefore there are no findings to report.

C. Proposed Evaluation Activities

The Agency intends to continue with the existing evaluation activities.

IX. Waiver and Expenditure Authorities

To effectively maintain the MMA program, the State is seeking a three-year extension of Florida's section 1115 Research and Demonstration waiver in order to waive statutory provisions under section 1902 of the Social Security Act and obtain expenditure authority that permits the State to provide maximum flexibility in administering Florida's Medicaid program.

The federal waiver and expenditure authorities requested for the program remain consistent with the current authorities granted by CMS on October 15, 2015. The State is not requesting waiver or expenditure authorities related to the LIP program. The Agency is exploring other avenues to continue this level of funding. See Attachment VI for a copy of the current approved Waiver and Expenditure Authorities.

ATTACHMENT I

LETTERS TO THE MICCOSUKEE AND SEMINOLE TRIBES

October 11, 2016

Ms. Cassandra Osceola
Health Director
Miccosukee Tribe of Florida
P.O. Box 440021, Tamiami Station
Miami, FL 33144

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida the State of Florida is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 to June 30, 2020. The MMA program operates statewide and provides primary and acute medical care, and behavioral health and dental care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

A full description of the proposed extension request is located on the Agency for Health Care Administrations (Agency's) website at the following link:
http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_extension_2016-10.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the extension request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from October 11, 2016 through November 10, 2016. The Agency has scheduled three public meetings to solicit meaningful input on the proposed waiver extension from the public. The meetings will be held in:

- Tallahassee, Florida: October 18, 2016, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Drive Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1 888 419 5570, and enter the participant passcode: 492 773 91#.
- Tampa, Florida: October 20, 2016, 11:30 a.m. – 1:00 p.m. at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Main Training Room, Tampa, FL 33614. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 498 282 50#.
- Miami, Florida: October 21, 2016, 10:00 a.m. – 11:30 a.m. at the Agency for Health Care Administration, 8333 NW 53rd St, Suite 200, Doral, FL 33166. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 474 080 47#.

If you have any questions about this amendment or would like to hold a call, please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

Beth Kidder
Interim Deputy Secretary for Medicaid

BK/hm

October 11, 2015

Ms. Connie Whidden, MSW
Health Director
Seminole Tribe of Florida
3006 Josie Billie Avenue
Hollywood, FL 33024

Dear Ms. Whidden:

This letter is being sent to notify the Miccosukee Tribe of Florida the State of Florida is seeking federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 to June 30, 2020. The MMA program operates statewide and provides primary and acute medical care, and behavioral health and dental care for Florida Medicaid recipients through competitively procured managed care plans. The State seeks to extend the MMA waiver to build upon the successful elements of the program including stronger protections for Florida Medicaid recipients.

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- Tampa, Florida: October 20, 2016, 11:30 a.m. – 1:00 p.m. at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Main Training Room, Tampa, FL 33614. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 498 282 50#.
- Miami, Florida: October 21, 2016, 10:00 a.m. – 11:30 a.m. at the Agency for Health Care Administration, 8333 NW 53rd St, Suite 200, Doral, FL 33166. To participate by phone, please call 1 888 419 5570 and enter the participant passcode: 474 080 47#.

If you have any questions about this amendment or would like to hold a call, please contact Heather Morrison of my staff via email at Heather.Morrison@ahca.myflorida.com or by phone at (850) 412-4034.

Sincerely,

Beth Kidder
Interim Deputy Secretary for Medicaid

BK/hm

ATTACHMENT II EXPANDED BENEFITS

| Expanded Benefits | | | | | | | | | | | | | | | | | |
|--|----------------|---------------|----------|--------|--------|----------|------------------------|--------|----------|----------|--------|-----------------|----------|---------|----------|-----------------------|-----------------|
| | Standard Plans | | | | | | | | | | | Specialty Plans | | | | | |
| | Amerigroup | Better Health | Coventry | Humana | Molina | Prestige | Community Care Network | Simply | Staywell | Sunshine | United | CMSN | Magellan | Freedom | Sunshine | Clear Health Alliance | Positive Health |
| Adult dental services | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Adult hearing services | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | | Y | Y | Y |
| Adult vision services | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Art therapy | Y | | | Y | Y | | | | Y | Y | | | | | Y | | |
| Equine therapy | | | | | | | | | Y | | | | | | | | Y |
| Home health care for non-pregnant adults | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | |
| Influenza vaccine | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Medically related lodging & food | | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | Y | | Y | Y | Y |
| Newborn circumcisions | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Nutritional counseling | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | Y | | Y | Y | |
| Outpatient hospital services | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Over the counter medication | Y | Y | Y | Y | Y | Y | | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Pet therapy | | | | Y | Y | | | | Y | | | | | | | | |
| Physician home visits | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | | | Y | Y | |
| Pneumonia vaccine | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Post-discharge meals | Y | Y | Y | Y | Y | | Y | Y | Y | Y | Y | | Y | | Y | Y | |
| Prenatal/perinatal visits | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Primary care visits for non- | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Shingles vaccine | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Waived co-payments | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y |
| Specialty Plans Only | | | | | | | | | | | | | | | | | |
| Home and community-based services | | | | | | | | | | | | | Y | | | Y | |
| Intensive outpatient therapy | | | | | | | | | | | | | Y | | | Y | |

ATTACHMENT III CURRENT COUNTIES BY REGION

| MMA Program Regions | |
|----------------------------|--|
| 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 |

ATTACHMENT IV CURRENT CONTRACTED PLANS

| MMA Plan Name | REGION | | | | | | | | | | | Total Number of Awards |
|--|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------------------------|
| RESPONDENT NAME | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | |
| General, Non-specialty Plans | | | | | | | | | | | | |
| Amerigroup Florida, Inc. | | | | | X | X | X | | | | X* | 4 |
| Better Health, LLC - PSN | | | | | | X | | | | X | | 2 |
| Coventry Health Care of Florida, Inc. | | | | | | | | | | | X* | 1 |
| Humana Medical Plan, Inc. | X | | | | | X | | | X | X* | X* | 5 |
| Molina Healthcare of Florida | X | | | X | | X | X | X | X | | X | 7 |
| Prestige Health Choice - PSN | | X | X | | X | X | X | X | X | | X | 8 |
| Simply Healthcare Plans, Inc. | | | | | | | | | | | X | 1 |
| Community Care Network | | | | | | | | | | X | | 1 |
| Sunshine State Health Plan, Inc. | | | X* | X* | X* | X* | X* | X* | X* | X* | X* | 9 |
| UnitedHealthcare of Florida, Inc. | | | X* | X* | | | X* | | | | X* | 4 |
| Wellcare of Florida, Inc. d/b/a Staywell Health Plan of Florida | | X | X | X | X | X | X | X | | | X | 8 |
| General, Non-specialty Plans Awarded | 2 | 2 | 4 | 4 | 4 | 7 | 6 | 4 | 4 | 4 | 9 | 50 |
| Specialty Plans | | | | | | | | | | | | |
| AHF MCO of Florida, Inc. d/b/a Positive Healthcare Florida HIV/AIDS Specialty Plan | | | | | | | | | | X | X | 2 |
| Florida MHS, Inc. d/b/a Magellan Complete Care Serious Mental Illness Specialty Plan | | X | | X | X | X | X | | X | X | X | 8 |
| Children's Medical Services | X | X | X | X | X | X | X | X | X | X | X | 11 |
| Freedom Health, Inc. Chronic Conditions/Duals Specialty Plan | | | X | | X | X | X | X | X | X | X | 8 |
| Simply Healthcare Plans, Inc. d/b/a Clear Health Alliance HIV/AIDS Specialty Plan | X | X | X | | X | X | X | X | X | X | X | 10 |
| Sunshine State Health Plan, Inc. Child Welfare Specialty Plan | X | X | X | X | X | X | X | X | X | X | X | 11 |
| Specialty Plans Awarded | 3 | 4 | 4 | 3 | 5 | 5 | 5 | 4 | 5 | 6 | 6 | 50 |

* Plans (by region) also authorized as Statewide Medicaid Managed Care (SMMC) Long-term care (LTC) plans under Florida's LTC managed care waiver.

ATTACHMENT V PERFORMANCE MEASURE RESULTS

| Calendar Years 2014 and 2015 Florida MMA Performance Measures | | | | | |
|--|------------------------------------|-------------------------------------|-----------------------|-------------------------------------|---|
| Measure | CY 2014 | | CY 2015 | | |
| | CY 2014 Weighted Mean ¹ | CY 2014 Comparison to National Mean | CY 2015 Weighted Mean | CY 2015 Comparison to National Mean | CY 2015 Comparison to CY 2014 Weighted Mean |
| Adolescent Well-Care | 53% | Higher | 53% | Higher | Same |
| Adults' Access to Preventive Care - 20-44 Yrs | 68% | Lower | 69% | Lower | Higher |
| Adults' Access to Preventive Care - 45-64 Yrs | 85% | Lower | 85% | Lower | Same |
| Adults' Access to Preventive Care - 65+ Yrs | 80% | Lower | 77% | Lower | Lower |
| Adults' Access to Preventive Care - total | 74% | Lower | 75% | Lower | Higher |
| Adult BMI Assessment | 86% | Higher | 86% | Higher | Same |
| Annual Dental Visit - total | 34% | Lower | 47% | Lower | Higher |
| Annual Monitoring for Patients on Persistent Medications - ACEs/ARBs | 92% | Higher | 91% | Higher | Lower |
| Annual Monitoring for Patients on Persistent Medications - Digoxin | 46% | Lower | 55% | Higher | Higher |
| Annual Monitoring for Patients on Persistent Medications - Diuretics | 92% | Higher | 91% | Higher | Lower |
| Annual Monitoring for Patients on Persistent Medications - total | 92% | Higher | 91% | Higher | Lower |
| Antidepressant Medication Mgmt. – Acute | 52% | Higher | 52% | At the mean | Same |
| Use of Appropriate Medications for People with Asthma | 84% | At the mean | N/A | N/A | N/A |
| Breast Cancer Screening | 59% | Higher | 61% | Higher | Higher |
| Call Answer Timeliness | 87% | Higher | 84% | Higher | Lower |
| Cervical Cancer Screening | 55% | N/A | 51% | Lower | Lower |
| Controlling Blood Pressure | 57% | Higher | 50% | Lower | Lower |
| Childhood Immunization Status - Combo 2 | 75% | Higher | 77% | Higher | Higher |
| Childhood Immunization Status - Combo 3 | 71% | At the mean | 72% | Higher | Higher |
| Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months | 96% | At the mean | 95% | At the mean | Lower |
| Children & Adolescents' Access to Primary Care | 89% | Higher | 89% | Higher | Same |

**Calendar Years 2014 and 2015
Florida MMA Performance Measures**

| Measure | CY 2014 | | CY 2015 | | |
|---|------------------------------------|-------------------------------------|-----------------------|-------------------------------------|---|
| | CY 2014 Weighted Mean ¹ | CY 2014 Comparison to National Mean | CY 2015 Weighted Mean | CY 2015 Comparison to National Mean | CY 2015 Comparison to CY 2014 Weighted Mean |
| Practitioners (PCPs) - 25 months-6 years | | | | | |
| Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years | 89% | Lower | 89% | Lower | Same |
| Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years | 86% | Lower | 86% | Lower | Same |
| Chlamydia Screening - 16-20 years | 57% | Higher | 59% | Higher | Higher |
| Chlamydia Screening - 21-24 years | 70% | Higher | 69% | Higher | Lower |
| Chlamydia Screening - total | 60% | Higher | 62% | Higher | Higher |
| Diabetes - HbA1c Testing | 85% | Higher | 81% | Lower | Lower |
| Diabetes - HbA1c Poor Control (INVERSE) | 42% | Lower (Better) | 48% | Higher (Worse) | Higher (Worse) |
| Diabetes - HbA1c Good Control | 48% | Higher | 43% | Lower | Lower |
| Diabetes - Eye Exam | 51% | Lower | 51% | Lower | Same |
| Diabetes - LDL Screening | 82% | Higher | N/A | N/A | N/A |
| Diabetes - LDL Control | 34% | At the mean | N/A | N/A | N/A |
| Diabetes - Nephropathy | 84% | Higher | 92% | Higher | Higher |
| Engagement of Alcohol and Other Drug Dependence Treatment - 13-17 years of age | 13% | Lower | 10% | Lower | Lower |
| Engagement of Alcohol and Other Drug Dependence Treatment - 18+ years of age | 6% | Lower | 5% | Lower | Lower |
| Engagement of Alcohol and Other Drug Dependence Treatment - total | 7% | Lower | 6% | Lower | Lower |
| Follow-up after Hospitalization for Mental Illness - 7 day | 24% | Lower | 36% | Lower | Higher |
| Follow-up after Hospitalization for Mental Illness - 30 day | 38% | Lower | 43% | Lower | Higher |
| Follow-up Care for Children Prescribed ADHD Medication - Initiation | 50% | Higher | 50% | Higher | Same |
| Follow-up Care for Children Prescribed ADHD Medication - Continuation and Maintenance | 61% | Higher | 63% | Higher | Higher |

| Calendar Years 2014 and 2015 Florida MMA Performance Measures | | | | | |
|--|------------------------------------|-------------------------------------|-----------------------|-------------------------------------|---|
| Measure | CY 2014 | | CY 2015 | | |
| | CY 2014 Weighted Mean ¹ | CY 2014 Comparison to National Mean | CY 2015 Weighted Mean | CY 2015 Comparison to National Mean | CY 2015 Comparison to CY 2014 Weighted Mean |
| Frequency of Prenatal Care - ≥ 81% of expected visits | 65% | Higher | 67% | Higher | Higher |
| Initiation of Alcohol and Other Drug Dependence Treatment - 13-17 years of age | 46% | Higher | 38% | Lower | Lower |
| Initiation of Alcohol and Other Drug Dependence Treatment - 18+ years of age | 43% | Higher | 40% | Higher | Lower |
| Initiation of Alcohol and Other Drug Dependence Treatment - total | 44% | Higher | 40% | Higher | Lower |
| Immunizations for Adolescents - Combo 1 | 65% | Lower | 67% | Lower | Higher |
| Lead Screening in Children | 62% | Lower | 61% | Lower | Lower |
| Prenatal Care | 84% | Higher | 83% | Higher | Lower |
| Postpartum Care | 60% | Lower | 59% | Lower | Lower |
| Well-Child First 15 Mos. - 0 Visits (INVERSE) | 3% | At the mean | 2% | At the mean | Lower (Better) |
| Well-Child First 15 Mos. – 6+ Visits | 55% | Lower | 58% | Lower | Higher |
| Well-Child 3-6 Years | 75% | Higher | 75% | Higher | Same |

¹Calendar year 2014 was a transition year as the MMA program was implemented by region starting in May and ending in August. 2014 results therefore include individuals who may have been in a Florida Medicaid delivery system other than MMA for part of the year.

ATTACHMENT VI WAIVER AND EXPENDITURE AUTHORITIES

FLORIDA MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION WAIVER AUTHORITIES

NUMBER: 11-W-00206/4
TITLE: Managed Medical Assistance Program
AWARDEE: Agency for Health Care Administration

All requirements of the Medicaid program expressed in law, regulation and policy statement, 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). The state acknowledges that it has not asked for, nor has it received, a waiver to Section 1902(a)(2). These waivers are effective beginning July 31, 2014, through June 30, 2017.

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)
and 1902(a)(17)**

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

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

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

**FLORIDA
MANAGED MEDICAL ASSISTANCE SECTION 1115
DEMONSTRATION EXPENDITURE AUTHORITIES**

NUMBER: 11-W-00206/4

TITLE: Managed Medical Assistance Program

AWARDEE: Agency for Health Care Administration

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration from July 31, 2014, through June 30, 2017, 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). The authorities also promote the objectives of title XIX in the following ways:

- Expenditure authorities 1 and 3 promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the state; and
 - Expenditure authority 2 promotes the objectives of title XIX by increasing access to, stabilizing, and strengthening providers to serve uninsured, low-income populations in the state
1. Expenditures for payments to managed care organizations, in which individuals who regain Medicaid eligibility within six months of losing it may be re-enrolled automatically into the last plan in which they were enrolled, notwithstanding the limits on automatic re-enrollment defined in section 1903(m)(2)(H) of the Act.
 2. For demonstration year 10, through June 30, 2016, and demonstration year 11, July 1, 2016- June 30, 2017, expenditures made by Florida for uncompensated care costs incurred by providers for health care services for the uninsured and or underinsured, subject to the restrictions placed on the Low Income Pool, as defined in the STCs.
 3. 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 64 and 65.



State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Justin Senior, Interim Secretary

2727 Mahan Drive
Tallahassee, FL 32308
ahca.myflorida.com

Mission Statement
Better Healthcare for All Floridians.