

Replacement Waiver

Statewide Managed Medical Assistance Program

1115 Research and Demonstration Waiver



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Table of Contents

I.	Statement of Purpose	1
II.	Statewide Managed Medical Assistance Program.....	4
III.	Eligibility and Enrollment	7
A.	Eligibility for Medicaid	7
B.	Eligibility for the Statewide Managed Medical Assistance Program	7
C.	Enrollment and Disenrollment.....	8
D.	Information and Choice	11
E.	Marketing.....	12
IV.	Benefits	13
A.	Customized Benefit Packages	13
V.	Delivery Systems	17
A.	Entities Regulated under Florida Insurance Statutes.....	19
B.	Provider Service Networks.....	19
C.	Specialty Plans.....	20
D.	Reimbursement.....	21
VI.	Accountability and Monitoring	23
A.	Contracting Assurances.....	23
B.	Plan Accountability and Performance Standards	24
C.	Program Integrity	25
D.	Achieved Savings Rebate	26
E.	Penalties and Sanctions	26
F.	Quality Initiatives	27
VII.	Additional Programs	30
A.	Healthy Start Program	30
B.	Program for All Inclusive Care for Children.....	32
C.	Comprehensive Hemophilia Disease Management Program	34
VIII.	Budget Neutrality.....	36
	Appendix A Performance Measures and Outcomes.....	51
	Appendix B Florida Medicaid Program	52
	Appendix C Children’s Medical Services Network	58
	Appendix D Plan Transition Process.....	62

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Statewide Managed Medical Assistance Program

I. Statement of Purpose

The Florida Medicaid program was created in 1970, and currently covers approximately 3 million Floridians. Although initially crafted as a medical care extension for persons who received federally funded cash assistance, during the 40 years the program has operated the State has exercised options as they became available under federal law to expand Medicaid coverage to categorically related groups in addition to mandatory categorically needy eligibility groups. Further, the State also receives federal matching funds to provide certain optional services, and has sought and received federal waivers to provide services through home and community based programs for individuals who might otherwise be institutionalized.

Florida currently has received federal approval for waiver authority under various sections of the Social Security Act to conduct regional and statewide demonstrations designed to cover uninsured populations and to implement new delivery systems without increasing costs. The State has used such authority to implement managed care programs to enhance access to quality care in a cost-effective manner. With the implementation of the Statewide Medicaid Managed Care Program, the State is seeking to streamline the State's various managed care programs into a more comprehensive and integrated program available throughout the State of Florida. Upon implementation, the vast majority of programs will sunset and individuals will receive services through the Statewide Medicaid Managed Care Program.

As in all other States, Florida (and the federal government) has experienced very rapid growth in Medicaid expenditures. Drivers of such costs include population growth, expansions due to federal mandates, and economic recessions; expanded coverage and utilization of services; growth of the aged and disabled population; technological advances in treatment resulting in more costly care; increased cost of long-term care; and increased drug costs. To illustrate the impact to Florida:

- From SFY 2006-07 to 2011-12, Medicaid expenditure growth for Florida has averaged 6.5% per year, and Medicaid average monthly caseload growth has averaged 7.4% per year. In State Fiscal Year (SFY) 2011-12, the average monthly Medicaid caseload will be close to 3.2 million individuals, and total Medicaid expenditures will exceed \$21 billion dollars.¹ Medicaid will represent approximately 33% of the entire State budget in SFY 2011-12. If these trends continue, it is anticipated that by SFY 2014-15 Medicaid will represent 41% of the State's total budget with expenditures over \$27 billion.
- Florida covers over 47 different services on a fee-for-service (FFS) basis and through contracted managed care entities not included in this demonstration waiver. Individuals can receive care through 19 contracted managed care organizations (MCOs); the statewide primary care case management (PCCM) system; MediPass; or a FFS Provider Service Network (PSN) outside the demonstration counties. In addition, the State maintains several carve-out programs for mental health services, dental care, and transportation outside the demonstration counties. These multiple delivery systems generate more than 140 million individual claims annually, from more than 110,000 service providers of all types.

¹ February 2011 Florida Social Service Estimating Conference Report

Statewide Managed Medical Assistance Program

As a result, Medicaid expenditures are growing faster than other components of State budgets, and State Legislatures are seeking solutions to make the program sustainable over the long term. Care delivery to recipients in the fee-for service setting described above is often fragmented and episodic. No incentive exists for service providers to deliver efficient or coordinated health care. Rather than engage in preventive routine care, recipients often do not seek care until they become ill, and such utilization of the health care system does not leverage the dollars spent to improve the health status of the Medicaid population. A managed care system would create incentives for MCOs to identify recipients with chronic health conditions and provide preventive therapies and health maintenance, rather than wait until conditions become so severe that intensive and expensive treatment is required.

To that end, in recent years Florida has exercised options available from the federal government to improve the coordination and quality of services to recipients, while ensuring the efficiency and effectiveness of the program. In late 2010, in preparation for the 2011 Legislative session, Florida's elected leaders passed a Memorial that provided a framework for policy changes to be considered in the 2011 session.²

In the 2011 legislative session, both the Florida House of Representatives and the Florida Senate held numerous committee meetings to consider options for an effective and sustainable Medicaid program. Significant time was given by both houses and relevant committees of the legislature to receive public testimony from all facets of the stakeholder community. The result of this wide-ranging input was the conclusion that policy change was imperative to ensure the quality and coordination of care for Medicaid recipients, maintain access to physicians and other providers of service, and to improve the financial integrity and predictability of the need for funding of the program by Florida's taxpayers.

Two major pieces of Medicaid legislation were passed and signed into law.³ This document is specific to CS/HB 7107, which provides for significant changes to build greater stability and accountability in Florida Medicaid managed care. The enclosed waiver amendment request seeks federal authority to implement these changes. Central to this legislation is the creation of the Statewide Managed Medical Assistance program which would provide primary and acute medical care for specified populations through competitively selected MCOs in 11 geographic regions of the State.

Objectives for moving populations from a fee-for-service system to managed care include:

- Providing incentives to providers and recipients for efficient utilization of services by providing for coordination of health care in the most appropriate and cost-effective setting.
- Providing individuals a meaningful choice of plans and benefits.
- Reducing fraud, abuse and waste through managed utilization of health care services.

Currently, approximately 43% of all Florida Medicaid recipients are served through a managed care delivery system; the remaining 57% of the population is served through the traditional fee-for-service program. Florida Medicaid is recognized as a leader in the battle against fraud and abuse and has put in place many automated and manual safeguards to detect and prevent

²Link to Memorial to Congress <http://www.flsenate.gov/Session/Bill/2010A/0004/BillText/er/PDF>.

³Links to CS/HB 7107 <http://www.flsenate.gov/Session/Bill/2011/7107/BillText/er/PDF>, and 7109 <http://www.flsenate.gov/Session/Bill/2011/7109/BillText/er/PDF>.

Statewide Managed Medical Assistance Program

inappropriate payments, but the scale of the program and \$21 billion taxpayer expenditure required the closest possible oversight to prevent inappropriate utilization and potential overbilling.

The provisions of the recently enacted legislation that established the managed care program included specific requirements to further enhance program integrity. The selection criteria for the competitive procurement of managed care plans include documentation of policies and procedures for preventing fraud and abuse. Potential contractors face strict requirements to disclose business relationships to guard against conflicts of interest or prior involvement in health care fraud. The legislation includes accountability provisions that include provider credentialing and monitoring, effective prepayment and post-payment review processes, enhanced plan financial and data reporting, and a mandatory compliance plan designed to prevent fraud and abuse. It is not feasible to conduct this level of review for over 110,000 current fee-for-service providers.

The challenges facing states to improve their Medicaid programs' design to produce optimum health outcomes and efficiently manage costs require significant changes in order to sustain this benefit for individuals with low incomes and resources. The amendment request seeks to use the current authorities already granted to implement Florida law which is designed to address these challenges.

The State believes that the Florida Medicaid Managed Medical Assistance Program provides the framework for evolution to a sustainable benefit without eliminating services or access for eligible individuals. Given the requested authority to implement this program, Florida Medicaid could transform relationships, improve accountability, and provide incentives for improved health outcomes.

Statewide Managed Medical Assistance Program

II. Statewide Managed Medical Assistance Program

Florida's Statewide Managed Medical Assistance program will be guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. The State's role has changed so that it is largely a purchaser of care, providing oversight focused on improving access and increasing quality of care. This program emphasizes personal responsibility and rewarding healthy behaviors.

The framework for the Statewide Managed Medical Assistance program was established in legislation passed by the legislature and signed by the Governor through a Memorial in a special legislative session in late 2010 and in legislation passed in the regular 2011 session.

1. The principles established for the Statewide Managed Medical Assistance program included:
 - Improved program performance by expanding key components of the Medicaid managed care program Statewide, while strengthening accountability for improved patient outcomes and preserving meaningful choices for participants. A key objective of improved program performance is to increase patient satisfaction.
 - Improved access to coordinated care by enrolling all Medicaid participants in managed care except those specifically exempted due to short-term eligibility, limited service eligibility, or institutional placement (other than nursing home care). A key objective of improved access to coordinated care is to ensure access to services not previously covered and to improve access to specialists. This program includes requirements for MCOs to schedule appointments with a primary care physician within 30 days for new enrollees.
 - Enhanced fiscal predictability and financial management by converting the purchase of Medicaid services to capitated, risk-adjusted payment systems and shared savings model. Strict financial oversight requirements are established for MCOs to improve fiscal integrity.
 - Use of the expertise of MCOs, including health maintenance organizations (HMOs), PSNs, and other types of managed care entities, to provide all coverage and services for medical assistance. A key objective of the program is to provide a choice of managed care plans throughout the state and to provide for enhanced individual choice.
 - Stabilization of plan participation by competitively procuring plans on a regional basis, extending plan contract period to five years, and imposing penalties for plan withdrawals which are designed to enhance continuity of care.
 - Phased implementation of the Statewide Managed Medical Assistance program, allowing for adequate development of Medicaid managed care across the State.

These principles will empower participants, provide for the accountability of providers, and facilitate program management and fiscal integrity for government.

2. Under the Statewide Managed Medical Assistance program, there are three fundamental elements:
 - Risk-Adjusted Premiums will be developed for Medicaid enrollees in managed care plans. The risk-adjusted premium will minimize the phenomenon of "adverse selection,"

Statewide Managed Medical Assistance Program

and in fact, provides an incentive for plans to take all necessary steps to identify Medicaid enrollees who have undiagnosed chronic conditions. Once a Medicaid enrollee has chosen a plan, the plan may receive a higher premium only if the enrollee has been diagnosed with a condition that merits the additional premium. Of course, once a plan has identified someone with a chronic condition, it is then to the plan's financial benefit to properly manage the enrollee's condition so as to avoid higher cost services typical of untreated chronic conditions.

- Enhanced Benefits/ Healthy Behaviors will be provided through the managed care plans. The Enhanced Benefit Panel will be operational until the implementation of the Statewide Managed Medical Assistance program. The procurement process will require managed care plans to establish a program to encourage and reward healthy behaviors. The State will monitor to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program and a substance abuse treatment plan.
- Low-Income Pool (LIP) will be maintained by the State to provide direct payment and distributions to safety net providers in the State for the purpose of providing coverage to Medicaid, the uninsured, and underinsured populations. Funds will be distributed to safety net providers that meet certain state and federal requirements.

The Statewide Managed Medical Assistance program will introduce more individual choice, increase access, and improve quality, efficiency and fiscal integrity while stabilizing cost. The State believes more integrated models that expand the medical home concept to manage all care will provide additional opportunity to better manage care. Therefore, the State will continue to increase the number of individuals enrolled in managed care plans that are capable of managing all of an individual's care. In addition, the State will allow flexibility to plans to structure benefit packages to better serve individuals – while ensuring that benefits offered are sufficient and actuarially equivalent to meet the needs of the population.

As further described in this document, the managed care plans will be procured through a competitive, negotiated selection of qualified managed care plans that meet strict selection criteria. The program will provide for a limited number of plans in 11 geographic regions to ensure stability but allow for significant patient choice and further ensure coverage in rural areas of the state. The State will initiate procurement of the plans no later than January 1, 2013, and fully implement the program by October 1, 2014.

To effectively implement the program, the State is requesting an amendment to 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 while the program will change substantially for the current demonstration program as there are key improvements. Specifically, the State requests waivers of statutory provisions to provide for:

- Approval and federal financial participation (FFP) for Statewide Managed Medical Assistance program benefits with cost-sharing for all Medicaid eligibility categories participating in the waiver.
- Approval and FFP for the Enhanced Benefit/ Healthy Behaviors Plan to enable managed care plans to administer programs to encourage and reward healthy behaviors.
- Approval and FFP for costs not otherwise matchable for Program for All Inclusive Care

Statewide Managed Medical Assistance Program

for Children services and the Healthy Start program.

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

While the federal authorities needed to implement the program remain consistent with the current authorities granted in the 5 pilot counties, it is important to note that the program includes substantial changes to improve upon the current program.

Statewide Managed Medical Assistance Program

III. Eligibility and Enrollment

A. Eligibility for Medicaid

The Department of Children and Families (DCF) is the administering agency responsible for processing Medicaid applications and determining Medicaid eligibility. The State will continue to use the same application and eligibility processes for all individuals, including participants in the Statewide Managed Medical Assistance program. Current income and asset limits will apply under the program, as will current residency and citizenship standards. There will be no limit on the number of individuals eligible for Medicaid as specified in the State Plan. The State assures that all applications will be processed in a timely manner.

B. Eligibility for the Statewide Managed Medical Assistance Program

Participation in the Statewide Managed Medical Assistance program will be mandatory for the following eligibility groups currently covered by Florida Medicaid:

1. Mandatory Population:

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

- Families whose income is below the TANF limit (23% of the FPL or \$303 per month for a family of 3) with assets less than \$2,000.
- Pregnant women with incomes above the 1931 poverty level.
- Poverty-related children whose family income exceeds the TANF limit as follows:
 - up to age one, family income up to 200% FPL.
 - up to age 6, family income up to 133% of FPL.
 - up to age 21, family income up to 100% FPL.

b. Aged and Disabled Group:

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

c. Children eligible under SSI.

d. Children with chronic conditions who participate in Children's Medical Services Network.

e. Children in foster care and who receive adoption subsidy.

f. Individuals eligible under a hospice-related eligibility group.

g. Individuals eligible for both Medicare and Medicaid will be required to participate in this program for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals' Medicare benefits. However, to facilitate enrollment, the State will automatically enroll individuals in a Medicare Special Needs Plan (SNP), if the individual has elected the plan under Medicare.

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

Statewide Managed Medical Assistance Program

2. Voluntary Populations:

Medicaid recipients who may voluntarily choose to participate in this program include:

- Individuals who have other creditable health care coverage, excluding Medicare.
- Individuals residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities, as defined in state law.
- Persons eligible for refugee assistance.
- Individuals who are residents of a developmental disabilities center.
- Individuals with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients waiting for waiver services.
- Poverty level children up to age one with family income above 185% of FPL but below 200% of FPL.

3. Exempt Population:

The following individuals are exempt from this program:

- Women who are eligible only for family planning services.
- Women who are eligible through the breast and cervical cancer program.
- Persons who are eligible for emergency Medicaid for aliens.
- Children receiving services in a prescribed pediatric extended care facility.

4. Expansion Population:

Individuals who lose eligibility for Medicaid, regardless of assets, will continue to have limited eligibility solely to access accrued funds in their individual Enhanced Benefit Account. The expansion eligibles will receive no other Medicaid benefits. The expansion population will be limited to individuals who have accrued funds in an individual enhanced benefit account.

Once the State implements the Statewide Managed Medical Assistance program and the plans offer a healthy behavior program, the State will sunset the current Enhanced Benefits program. However, the individuals with unused earned credits will continue to have access to those credits for a specified period of time.

C. Enrollment and Disenrollment

Upon implementation of the program, the State anticipates developing a staggered transition plan in each region to transition individuals into the managed care plans once selected as part of the procurement process.

1. New Medicaid Enrollees:

At the time of eligibility determination, individuals in mandatory populations will receive information about the managed care plan choices in their area. They will be informed of their option to select an authorized plan within 30 days of eligibility. If the individual does not select a plan within the 30-day period, the State will auto-assign the individual to a managed care plan. Once individuals have made their choice, they will be able to contact the State or the State's designated Choice Counselor to register their plan selection or complete enrollment through the online process.

Statewide Managed Medical Assistance Program

2. Current Medicaid Enrollees:

For current Medicaid enrollees in a mandatory population, the State will develop a staggered transition plan for enrollment in the Statewide Managed Medical Assistance Program. Current Medicaid enrollees who are enrolled in a managed care plan or the MediPass program, will be required to enroll in a contracted plan, selected through competitive procurement process, at the time of their eligibility redetermination, or their open enrollment period, whichever is sooner. The State may create an open enrollment process for all enrollees.

The State will carefully plan the transition of the affected recipients into the program to preserve continuity of care. The State will follow a multi-layered approach in the design of the transition plan by:

- Assessing the capacity of the contracted plans.
- Coordinating with the contracted plans to identify primary care providers and supply service information to ensure continuity of care and minimize disruption to the recipients.
- Coordinating with the new contracted plans to identify any members in active behavioral health care to facilitate a written care coordination plan.
- Comparing provider networks to ensure continuity of care and continued availability of current primary care and behavioral health providers with the new plan.
- Coordinating with the contracted plans and the State's designated contractor to create a staggered transition to ensure that the volume of beneficiaries being transitioned occurred in an organized manner.
- Coordinating with the new contracted plans, the State's designated contractor, local area staff, and advocacy groups in ensuring appropriate and timely notice to enrollees, including developing and releasing flyers to locations and providers frequented by impacted enrollees to help ensure recipients understand the changes that are occurring.

Additional details regarding the transition of care are provided in Appendix D.

Medicaid recipients in the demonstration areas, who are not currently enrolled in a contracted plan upon implementation, will have the opportunity to enroll in a plan at the time of open enrollment or annual eligibility redetermination. The individual may choose to contact the toll free help line to talk about their managed care plan options. If the individual does not make a selection, the State will auto-assign the individual to a managed care plan to ensure that services will continue uninterrupted.

3. Auto-Assignment

Each enrollee will be given 30 days to select a managed care plan after being determined eligible for Medicaid. Within the 30-day period, the State or State's designate will provide information to the individual to encourage an active plan selection. Enrollees who fail to choose within this timeframe will be auto-assigned to a plan in their region. At a minimum, the State will use the parameters listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the State will make enrollee assignments consecutively by family unit.

Statewide Managed Medical Assistance Program

The State will use the following parameters when assigning a recipient to a plan:

- If an applicable specialty plan is available, the recipient should be assigned to the specialty plan;
- If, in the first year of the first contract term only, a recipient was previously enrolled in a plan that is still available in the region, the recipient should be assigned to that plan.
- Newborns of eligible mothers enrolled in a plan at the time of the child's birth shall be automatically enrolled in that plan; however, the mother may choose another plan for the newborn within 90 days after the child's birth.

In addition, when automatically enrolling a recipient into a plan, the State will consider:

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

The State will seek to preserve an existing provider-recipient relationship by considering whether the recipient has received services from one of the primary care providers in the plan's provider network in the past.

4. Lock-In/Disenrollment

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

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

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

Statewide Managed Medical Assistance Program

5. Re-enrollment

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

D. Information and Choice

1. Enrollee Choice

Potential enrollees in the demonstration regions will initially have the choice of enrolling in a managed care plan. Potential enrollees will have a choice of two or more managed care plans in each region. Plans may include:

- HMOs,
- PSNs (FFS or capitated),
- Accountable Care Organizations (defined in federal law),
- EPOs, or
- CMS Network.

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

2. Enrollee Information

The State or the State's designee will ensure that enrollees are provided with full and complete information about their managed care plan options. The State anticipates contracting for these services. The State or State's designee will provide information regarding an individual's choice to select a managed care plan.

Through the contractor, the State will develop enrollee education so individuals will fully understand their choices and will be able to make an informed selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly. Specifically, the State or State's designee will provide information on selecting a managed care plan.

As it does now, the State or the State's designated contractor will provide information about each plan's coverage in accordance with federal requirements. Additional information will include, but is not limited to, benefits and benefit limitations, cost-sharing requirements, network information, prescription drug formulary, contact information, performance measures, results of consumer satisfaction reviews, and data on access to preventive services. Individuals will be assured of equal value among plans since all plans will be actuarially equivalent. In addition, the State will supplement coverage information by providing performance information on each plan. Information provided may include medical loss ratios that indicate the percentage of the premium dollar attributable to direct services, enrollee satisfaction surveys and performance

Statewide Managed Medical Assistance Program

data. To ensure the information is as helpful as possible, the State may synthesize information into a coherent rating system. Such a system will better convey the performance of the managed care plans in an easy-to-understand format.

Enrollment materials will be provided in a variety of ways including print, telephone, online and face-to-face. All written materials shall be at the fourth-grade reading level and available in a language other than English when 5% of the county speaks a language other than English. The State or State's designee will also provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY. Individuals will be able to contact the State or the State's designated contractor to obtain additional information. The State or State's designated contractor will operate a toll-free number that individuals may call to ask questions and obtain assistance on managed care options. The call center will be operational during business days, with extended hours, and will be staffed with professionals qualified to address the needs of the enrollees and potential enrollees.

The State assures the Centers for Medicare and Medicaid Services that it will provide information in accordance with Section 1932(a)(5) of the Act and 42 CFR 438.10, Information Requirements.

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

E. Marketing

Approved managed care plans will not be allowed to market for enrollment to any potential members. Plans will be allowed to engage in brand-awareness activities, including the display of plan or product logos. With State approval, the plans will be allowed to conduct community outreach. Community outreach includes, but is not limited to, the provision of health or nutritional information or information for the benefit and education of, or assistance to, a community in regard to health-related matters or public awareness that promotes healthy lifestyles. In addition, the State will assure that all plans comply with section 1932(d)(2) of the Act and 42 CFR 438.104, Marketing Activities.

All materials provided by the plans will meet the requirements at 42 CFR 438.10, Informing Requirements, including being written at a fourth-grade reading level. The State will require translation of all enrollment and marketing materials in areas where a specific language is spoken by 5% or more of the population. In addition, the State or State's designated contractor and plans will provide oral translation services to all individuals, regardless of the language spoken. Plans will be required to have TTY/TDD service available for enrollees with hearing and speech impairments.

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

Statewide Managed Medical Assistance Program

IV. Benefits

The Statewide Managed Medical Assistance program will provide individuals with health care options that will allow them to better manage their health care. Currently, the Medicaid benefit package is one-size-fits all, leaving Medicaid enrollees with a single option for services, regardless of need. In many of the benefit “silos” that exist today, there are statewide limits and caps on various services that have varying impact on local populations.

The Statewide Managed Medical Assistance program will provide health plans with the flexibility to develop customized benefit packages that better fit and are more appropriate for Medicaid enrollees. Since these plans will be defined locally and will likely take advantage of varying strengths of the providers in that community, they will be more appropriate to the needs of that particular population. Such packages will more closely resemble private plans, yet will be actuarially equivalent to the current Medicaid benefit package. As part of the competitive procurement process, each plan will face the competitive pressure of offering the most innovative package within the limits of the premium offered by the State. At all times, the State will ensure the benefit packages are available at an actuarially appropriate level. The State seeks to ensure that needed services are covered and provided. With increased choices, individuals will be able to use their premium to select benefit plans that best meet their needs.

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

In addition, as part of the competitive bid process each plan will be required to create an enhanced benefit program. The purpose of the plan’s enhanced benefit program is to offer incentives to enrollees to participate in wellness activities. These activities will be designed to improve and/or maintain the enrollee’s health by providing individuals with a comprehensive benefit package.

A. Customized Benefit Packages

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

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

Statewide Managed Medical Assistance Program

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

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

1. Actuarial Equivalency

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

Actuarial equivalence is evaluated at the target population level and is measured based on that population's historical utilization of services for current Medicaid State Plan services. This process will ensure that, given a specified Medicaid target population and its historical utilization, the expected claim cost levels of all managed care plans are equal (using a common benchmark reimbursement structure) to the level of the historic fee-for-service plan. The State will use this as the first threshold to evaluate the customized benefit package submitted by a plan to ensure that the package earns the premium established by the State. In assessing actuarial equivalency, the evaluation model will consider the following components of the benefit package: services covered; cost sharing; additional benefits offered, if any; and any global limits.

2. Sufficiency

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

Thus, in order for a health plan to obtain State prior approval of its proposed customized benefit package, the proposed benefit package must be actuarially equivalent to the current Medicaid State Plan benefits for each target population and must cover key benefits at a level sufficient to meet the needs of the target population. Recipients will have the option to choose a managed care plan with a benefit package that best fits their needs. For example, one plan's benefit package may offer fewer chiropractic visits and more vision benefits than another plan's benefit package. If the recipient does not need a chiropractor but wears glasses, he/she may wish to

Statewide Managed Medical Assistance Program

choose a plan with a benefit package that offers more vision benefits. The State believes that the flexibility to offer customized benefit packages, combined with the two-pronged Benefit Plan Evaluation Model, will ensure optimal benefit packages for plan enrollees.

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

3. Cost Sharing

Under the Statewide Managed Medical Assistance program, the contracted plans may impose cost-sharing requirements consistent with the currently approved nominal levels in the State Plan. Current cost-sharing, including co-payments and co-insurances, are:

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

All individuals not exempt by federal regulation will be responsible for cost-sharing for services. The State will review and approve cost-sharing requirements as part of the benefit packages. Consistent with 42 CFR 447.53(b), cost-sharing will not be required for children through age 18, pregnant women, institutionalized individuals, emergency service or for family planning services and supplies, unless otherwise authorized by the Centers for Medicare and Medicaid Services. The State will also encourage managed care plans to reduce or waive cost-sharing requirements for preventive services in order to increase access and decrease dependence on more acute care services. Such services include, but are not limited to, check-ups, vaccinations, pap smears, and certain prescribed medication. The State believes that, due to the transparency of outcomes built into the Statewide Managed Medical Assistance program – particularly with each plan’s ability to maximize the number of people who receive preventive services - plans will be incentivized to remove all barriers to preventive services, including

Statewide Managed Medical Assistance Program

waiving cost sharing for those services. When a co-payment or co-insurance is required as part of the plan benefit structure, the provider will be responsible for collecting payments from individuals.

4. Enhanced Benefit /Healthy Behaviors Plan

The State will directly manage the development of policies and procedures that govern the Enhanced Benefit plan by maintaining the Enhanced Benefit Panel until the implementation of the Statewide Managed Medical Assistance program. As part of the procurement process in 2013, each selected plan shall be required to establish a program to encourage and reward healthy behaviors. At that time, the State will monitor the plans programs. Consistent with state law, at a minimum each plan must establish a medically approved smoking cessation program, a medically directed weight loss program, and a substance abuse program. These programs may be modified by the Legislature.

The State will continue operation of the panel to guide in the development and evaluation of the healthy behavior program offered by the plans. Panel composition will be determined by the Secretary of the Agency for Health Care Administration. The purpose of the panel will include, but not be limited to, the following duties:

- Designating activities that may be beneficial to individuals;
- Informing recipients of a proposed activity to enrollees;
- Establishing appropriate incentivizes for participation;
- Evaluating participation levels;
- Evaluating outcomes;
- Discussing operational issues; and
- Developing recommendations for administration.

Statewide Managed Medical Assistance Program

V. Delivery Systems

1. Procurement Method

The State will competitively procure managed care plans to provide services. The State will initiate separate but simultaneous procurements in each of the 11 regions. The State will begin implementation of the Statewide Managed Medical Assistance program no later than January 1, 2013, with full program implementation by October 1, 2014. Once the State has issued the procurement and awarded the contracts, the State will prepare a detailed transition plan based on plan readiness and capacity.

The criteria for preference in reviewing ITN respondents include: accreditation by nationally recognized accrediting bodies; 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; and documentation of policies for preventing fraud and abuse. The State will enter into five-year health plan contracts with selected contractors. The table below provides a high level overview of the draft timeframe for procurement and implementation.

Managed Medical Assistance Program Draft Timeline

Phase	Begin	End
Geographic Expansion Implementation Criteria	9/2011	10/2011
Continuity of Care Planning	3/2012	5/2012
Systems Analysis and Recommendations	12/2011	5/2012
Develop Solicitation	3/2012	12/2012
ITN Release	No Later Than 1/2013	No Later Than 1/2013
Databook Release	10/1/2012	10/1/2012
Contracts and Awards	4/2013	9/2013
Provider and Recipient Outreach and Education	Ongoing	Ongoing
Readiness Reviews	12/2013	9/2014
Enrollee Plan Selection Process and Materials Development	10/2013	3/2014
Enrollee Notification and Enrollment	4/2014	9/2014

2. Managed Care Plans Defined

A managed care plan is defined as an eligible plan under contract with the State to provide services in the Medicaid program and a prepaid plan is defined as a managed care plan that is licensed or certified as a risk-bearing entity in the State, or qualified pursuant to Florida Statutes, that is paid a prospective per-member, per-month payment by the Agency.

An “eligible plan” is defined as a health insurer authorized under Chapter 627, an EPO authorized under Chapter 627, a HMO authorized under Chapter 641, a PSN authorized under

Statewide Managed Medical Assistance Program

state law, an ACO authorized under federal law, or the Children's Medical Services Network authorized under state law.

3. Number of Plans per Region

The State will procure a specified number of plans per region. A minimum and maximum number of plans is specified by region, with a minimum of two plan choices in each of the 11 regions. Of the total contracts awarded per region, at least one plan shall be a PSN if any PSNs submit a responsive bid. Issuance and award of the procurements will provide for a choice of plans, as well as market stability as the State will seek to enter into five-year contracts and penalize plans for early withdrawal from a region(s) prior to the end of the contract term or reduction in contracted enrollment levels.

To the extent that there are fewer than two plan choices in a region, the State will issue another procurement to obtain a second plan and meet the federal requirements regarding choice until two plans are available. Additionally, participation by the Children's Medical Services Network shall be pursuant to a single, Statewide contract with the Agency that is not subject to the procurement requirements or regional plan number limits but requires adherence to general plan network and quality requirements.

In addition, the State will also seek to contract with specialty plans and participation of specialty plans will be part of the procurement requirements as well as the regional plan number limits. However, the State may enter into contracts with a specialty plan whose target population includes no more than 10% of the enrollees of that region. Such specialty plans are not subject to the regional plan number.

4. Plan Selection Criteria

As part of the ITN process, the State will establish preference criteria for reviewing respondents as previously described. Such criteria will include, but not limited to, the State's evaluation of whether plans have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards; have well-defined programs for recognizing patient-centered medical homes and providing for increased compensation for recognized medical homes, as defined by the plan; have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings; have a claims payment process that ensures that claims that are not contested or denied will be promptly paid under state law; are organizations that are based in and perform operational functions in this State, in-house or through contractual arrangements, by staff located in this State; and have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Types of Contracted Plans

The types of contracted plans the State will contract with include: HMOs, PSNs, ACOs authorized under federal law, EPOs, and the State's Children's Medical Services Network operated by the Florida Department of Health. Refer to Appendix C for additional information on the Children's Medical Services Network. The State will reimburse most contracted plans on a capitated basis; however, fee-for-service payments may be used for PSN providers for a time limited period as authorized in state law.

As described in Section IV., Benefits, capitated plans may create customized benefit packages

Statewide Managed Medical Assistance Program

that vary in amount, duration, and scope from State Plan services. Those PSN plans that continue to be paid on a FFS basis will not be permitted to vary the amount, duration, or scope of services from that set out in historical Medicaid.

Below is a description of the provider types.

A. Entities Regulated under Florida Insurance Statutes

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

The contracted plans are required to be licensed, full risk-bearing entities. In accordance with 42 CFR 438.2, comprehensive risk is defined as a managed care plan that is at-risk for inpatient hospital services and three or more mandatory State Plan services in section 1905(a). Entities assuming risk consistent with federal requirements and receiving capitation payment will be considered a comprehensive risk-bearing entity and be required to meet state fiscal and solvency standards.

1. HMOs: Health Maintenance Organizations

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

2. Licensed Insurers

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

- EPO: Exclusive Provider Organization – A provider of health care or a group of providers that has entered into a written agreement to provide benefits under a health insurance policy. EPOs are not directly regulated as to solvency by the Office of Insurance Regulation but typically contract through another entity that is so regulated, such as an HMO or an Insurance Company.

The Agency will work with the Office of Insurance Regulation to determine appropriate solvency provisions for any EPOs with which the State contracts with as part of the Statewide Managed Medical Assistance program.

B. Provider Service Networks

PSNs are networks established or organized and operated by a health care provider, or group of affiliated health care providers, which provide a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers. They may make arrangements with physicians or other health care professionals, health care

Statewide Managed Medical Assistance Program

institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the PSN.

In accordance with Florida Statutes, the State may reimburse a PSN on either a fee-for-service or prepaid basis. Once capitated, all PSNs will be required to assume responsibility for comprehensive coverage and meet established solvency standards. Capitated PSNs are exempt from many of the regulatory provisions that apply to HMOs under parts I and III of Chapter 641, Florida Statutes, unless they serve other populations, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the State. Once a PSN accepts capitation, it must meet the same surplus and solvency requirements as HMOs, consistent with licensed HMOs in Chapter 641, Florida Statutes, and s. 409.912, Florida Statutes. Chapter 641 requires that an entity shall at all times maintain a minimum surplus in an amount that is the greater of \$1,500,000, or 10% of total liabilities, or 2% of total contract amount. The State may also consider the following:

- If the organization is a public entity, the Agency may take under advisement a Statement from the public entity that a county supports the managed care plan with the county's full faith and credit. In order to qualify for the Agency's consideration, the county must own, operate, manage, administer, or oversee the managed care plan, either partly or wholly, through a county department or agency;
- The State guarantees the solvency of the organization; or
- The entity meets the financial standards for federally approved provider-sponsored organizations as defined in 42 C.F.R. s. 422.350, subpart H, or ss. 422.380-422.390.

In addition to the fee-for-service specialty plan operated by the Florida Department of Health for children with chronic conditions, currently, the State contracts with six PSNs that, cumulatively, provide services in 34 counties.

C. Specialty Plans

The contracted plans will be encouraged to develop and offer specialty plans to serve individuals with specific conditions or select eligibility groups.

A specialty plan is defined as a plan that exclusively enrolls, or enrolls a disproportionate percentage of, special needs individuals and that has been approved by the State as a specialty plan. Specialty plans are designed for a specific population and currently include plans that primarily serve children with chronic conditions or recipients who have been diagnosed with the human immunodeficiency virus or acquired immunodeficiency syndrome (HIV/AIDS). A health plan must be licensed under Chapter 641, F.S., to offer a specialty plan for recipients living with HIV/AIDS. Participation of specialty plans will be part of the procurement requirements and the aggregate enrollment of all specialty plans in a region may not exceed 10% of the enrollees of that region. .

The State will identify specialty plans as part of the procurement process and may approve specialty plans on a case-by-case basis using criteria that include appropriateness of the target population and the existence of clinical programs or special expertise and/or providers to serve that target population. The State will not approve plans that discriminate against sicker members of a target population.

Statewide Managed Medical Assistance Program

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

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

- Appropriate integrated provider network of primary care physicians and specialists who are trained to provide services for a particular condition or population. The network should be an integrated network of primary care physicians (e.g., nephrologists for kidney disease; cardiologists for cardiac disease; infectious disease specialists and immunologists for HIV/AIDS).
- Network with sufficient capacity of board-certified specialists in the care and management of the disease for plans that seek to focus services for enrollees with a particular disease state. In addition, it is recognized that individuals have multiple diagnoses, and, therefore, the plan should have sufficient capacity of additional specialists to manage the different diagnoses.
- Defined network of facilities that are used for inpatient care, including the use of accredited tertiary hospitals and hospitals that have been designated for specific conditions (e.g., end stage renal disease centers, comprehensive hemophilia centers).
- Availability of specialty pharmacies, where appropriate.
- Availability of a range of community-based care options as alternatives to hospitalization and institutionalization.
- Clearly defined coordination of care component that links and shares information between and among the primary care provider, the specialists, and the patient to appropriately manage co-morbidities.
- Use of evidence-based clinical guidelines in the management of the disorder.
- Development of a care plan and involvement of the patient in the development and management of the care plan, as appropriate.
- Development and implementation of a disease management program specific to the specialty population(s) or disease state(s), including a specialized process for transition of enrollees from disease management services outside of the plan to the plan's disease management program.

D. Reimbursement

Capitation rates will be developed in accordance with 42 CFR 438.6. The State will develop actuarially sound, risk-adjusted premiums. The premiums will be based on historical Medicaid expenditures including the use of encounter data, but will be appropriate for the various benefit packages that entities propose due to the requirement that those benefit packages be actuarially equivalent to historical Medicaid expenditures.

The State will reimburse some PSNs on a fee-for-service basis with a shared savings arrangement and all other managed care plans on the basis of the risk-adjusted capitation premiums. Risk adjustment will be used to reflect differences in health status of enrollee and

Statewide Managed Medical Assistance Program

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

1. Risk-Adjusted Capitation Premiums

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

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

The State currently utilizes a health-based risk adjustment model to adjust rates for capitated plans in five Reform counties. The purpose of health-based risk adjustment is to provide a risk score for each individual receiving services through Medicaid which reflects their predicted health care needs. The scores of all of the individuals enrolled in each plan determine the collective risk score and the resulting premiums for that plan. The State will work with its contracted actuary to update and enhance risk adjustment methodologies to reflect nationally recognized models best suited for this program.

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

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

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

2. Fee-for-Service Reimbursement

The State may pay some or all PSNs on a fee-for-service (FFS) basis as authorized by legislation, using historical Medicaid covered services with no variation of benefit package. The State will not reimburse a FFS-based PSN for services not authorized under the State Plan. PSNs may provide and directly pay for additional services through any savings earned at no cost the State.

The State will work with the actuary to develop guidelines for phasing in financial risk for PSNs. Any phase-in shall be converted to a risk-adjusted capitated premium as specified in state law.

Statewide Managed Medical Assistance Program

VI. Accountability and Monitoring

The Agency will follow standard State contracting procedures to enter into clear and comprehensive managed care contracts developed prior to procurement that are consistent with all state and federal requirements. The Agency will specify monitoring activities and contractual accountability standards to ensure access to and the delivery of high quality health care by all contracted plans to enrollees. The overarching goal is to promote the health and well being of enrollees by assuring enrollee access to services, holding contracted plans accountable for outcomes, and promoting quality and cost-effective delivery of services. Other tenets of the Statewide Managed Medical Assistance program are as follows:

- Comprehensive transition requirements for implementing the program
- Increased stability among health plans
- Comprehensive transition requirements when plan changes are necessary
- Limits on the number of participating plans in the eleven regions
- Plan selection criteria
- Network adequacy
- Plan solvency
- Penalties for not completing a contract term
- Penalties for failure to comply with encounter data reporting requirements

A. Contracting Assurances

Provider Network Requirements

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

In evaluating adequacy of networks for managed care plans, the State will consider the demographics of a community and availability of services locally. In geographic areas where there are a large number of Medicaid recipients, the State will require contracted plans to demonstrate access to an adequate network of health care providers serving that community.

In order to ensure access to necessary Medicaid services, the State is directed to establish specific standards for the number, type, and regional distribution of providers in plan networks. The State will ensure that plans maintain a network of providers in sufficient numbers to meet the needs of the recipients. Specifically, the 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. Plans will be required to have providers available within reasonable travel and distance standards comparable to standards established by the State.

In addition, plans will be required to establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the State deems necessary. The provider database must be available online to both the Agency and the public and allow comparison of the availability of providers to network adequacy standards, and accept and display feedback from each provider's patients.

Statewide Managed Medical Assistance Program

Plans may limit the providers in their networks, if network adequacy standards are met, but must include providers classified by the Agency as “essential,” which shall include at a minimum:

- Federally qualified health centers,
- Statutory teaching hospitals as defined in state law,
- Hospitals that are trauma centers as defined in state law, and
- Hospitals located at least 25 miles from any other hospital with similar services.

The Agency will also identify statewide essential providers. These providers are to include:

- Faculty plans of Florida medical schools,
- Regional perinatal intensive care centers as defined in state law,
- Hospitals licensed as specialty children’s hospitals as defined in state law, and
- Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Plans are required to negotiate in good faith with essential providers for one year and reimbursement rates for these essential providers are specified.

In addition to the essential providers and statewide essential providers, plans will be required to offer a network contract to each home medical equipment and supplies provider that meets quality and fraud and abuse prevention and detection standards established by the plan.

The Agency may authorize plans to include providers located outside of their region if appropriate to meet time and distance or other network adequacy requirements standards. While plans may use mail order as a pharmacy option, the exclusive use of mail-order pharmacies is not sufficient to meet network access standards. Furthermore, the Agency will evaluate each plan’s pharmacy network to assure reasonable access.

In addition, as previously noted, the Agency is directed, when selecting plans based on ITN responses, to evaluate those responses, in part, based on the availability and accessibility of primary care and specialty physicians in the network and the establishment of partnership with community providers that provide community based services.

B. Plan Accountability and Performance Standards

The Agency will transition monitoring activities from the current Medicaid managed care program to provide enhanced plan accountability and clear performance standards. These enhanced requirements include, but are not limited to: posting of formulary or preferred drug list on the plan’s website and ensure the list is updated within 24 hours of any change; acceptance of electronic prior authorization requests; establishment of an internal health care quality improvement system with enrollee satisfaction and disenrollment surveys as well as incentives and disincentives for network providers; collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS) measures with results published on each plan website; accreditation within 1 year of contract execution; establishment of programs and procedures to improve pregnancy outcomes and infant health; and notification of the Agency of the impending

Statewide Managed Medical Assistance Program

birth of a child to an enrollee. The Agency will conduct periodic contract oversight and monitoring reviews to ensure plan compliance with contract requirements and develop a thorough and consistent oversight review process so that plans are held to consistent standards.

Grievance and Appeals

The Agency will maintain and ensure a grievance process for plans that:

- Requires each plan to have an approved internal grievance system that is consistent with federal law and allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H and Subpart F Grievance System, in-so-far as these regulations are applicable.
- Maintains a State-level panel to hear appeals of grievances not resolved at the plan level.
- Preserves the Medicaid fair hearing process that requires each Medicaid managed care plan to provide Medicaid enrollees with access to the State Fair Hearing process as required under 42 CFR 431 Subpart E, including:
 - Informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
 - Ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if the State takes action without the advance notice and as required in accordance with State policy consistent with Fair Hearings. The State must also inform enrollees of the procedures by which benefits can be continued or reinstated, and
 - Other requirements of Fair Hearing found in 42 CFR 4331, Subpart E.

C. Program Integrity

The State assures the Medicaid program integrity system will require each Medicaid MCO to comply with Section 1932(d)(1) of the Social Security Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State will prohibit any of the Medicaid MCOs from knowingly having a relationship with:

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

The prohibited relationships are:

1. A director, officer, or partner of the Medicaid MCO,
2. A person with beneficial ownership of 5% or more of the Medicaid MCO's equity,
3. A person with an employment, consulting or other arrangement with Medicaid MCO

Statewide Managed Medical Assistance Program

for the provision of items and services that are significant and material to the Medicaid MCO's obligations under its contract with the State.

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

The program integrity system will require each Medicaid MCO to comply with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in-so-far as these regulations are applicable.

The payments to each Medicaid MCO will be based on data submitted by the MCO and will be required to be in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

D. Achieved Savings Rebate

To promote fiscal accountability, the Agency will establish an achieved savings rebate program. Under the program, the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5% of revenue shall be retained by the plan.
2. Fifty percent of income above 5% and up to 10% shall be retained by the plan, and the other 50% refunded to the State.
3. One hundred percent of income above 10% of revenue shall be refunded to the State.

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

E. Penalties and Sanctions

To ensure stability, the Agency will impose new penalties for plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the Agency for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other plans must pay a penalty of 25% of the minimum surplus requirement pursuant to state law. Plans are required to provide at least 180 days notice to the Agency before withdrawing from a region. If a contracted plan leaves a region before the end of the contract term, the agency is required to terminate all contracts with that plan in other regions.

Statewide Managed Medical Assistance Program

If a plan that is awarded an “additional contract” to ensure plan participation in Regions 1 and 2 is subject to penalties pursuant to state law for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. The plan is required to reimburse the Agency for the cost of enrollment changes and other transition activities.

If the Agency terminates a contract with a plan for a region or regions, the Agency will develop a plan to transition enrollees to other plans and may phase-in the terminations over a time period sufficient to ensure a smooth transition for affected enrollees. Such transition plans shall consider transition of enrollees under case management and those with complex medication needs, and existing provider or care relationships.

The Agency will also impose fines for failure to comply with encounter data reporting requirements. If the plan fails to comply within certain timeframes, the Agency will assess a daily fine for each day of non-compliance beginning on the 31st day. In addition, the Agency will notify the plan that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

F. Quality Initiatives

Improved quality and performance has been a key component of the State’s managed care strategy, and will continue to be a primary focus of the Statewide Managed Medical Assistance program.

Quality and performance measurement will play a primary role in the selection of managed care plans during the procurement process in the Statewide Medicaid Managed Care program. Accreditation by a nationally recognized accrediting body, the organization’s record in achieving specific quality standards, and the organization’s documented commitment to quality improvement will be among the criteria for selection.

Once contracts are finalized, quality oversight will exist on two levels: at the Agency and at individual managed care plans. The Agency has a written strategy for assessing and improving the quality and appropriateness of care delivered by all managed care plans to their enrollees. This strategy targets overall system improvement and specifies the steps the Agency will take to hold plans accountable for on-going quality:

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

Statewide Managed Medical Assistance Program

Reporting requirements by the contracted plans as a component of the quality strategy including, but are not limited to:

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

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

The managed care plans are currently required to develop and document a Quality Improvement Plan (QIP) that guides the efforts that will be taken at the managed care plan level to improve quality in both clinical and non-clinical areas of operation. As part of the Statewide Medicaid Managed Care program plan, the QIP will be required to include enrollee satisfaction and disenrollment surveys. The Agency reviews and approves the managed care plans' QIPs.

Managed care plans are currently required to report annual audited performance measures that include both HEDIS (Healthcare Effectiveness Data and Information Set) and HEDIS-like, or Agency-defined, measures, and this reporting will continue under the Statewide Medicaid Managed Care program.

A key component is continuous improvement. Below highlights select measures which demonstrate recipient improvements. These measures target both preventive and illness-based care and include measures for special populations such as recipients of behavioral health care services and enrollees with HIV/AIDS. The Agency re-assesses the list of required measures annually to comply with any changes to HEDIS made by the National Committee for Quality Assurance (NCQA) and to ensure that the list optimally targets key priorities for managed care in Florida.

All Florida Medicaid managed care plans have been required to report an array of HEDIS and HEDIS-like performance measures, beginning in 2008 (reporting year 2007). The performance for the demonstration plans and the non-demonstration plans has steadily improved overall with demonstration plans outperforming non-demonstration plans on most measures. In 2009, all demonstration plan performance measures improved with the exception of one plan and the demonstration plans out-performed non- demonstration plans in 20 of 27 reported measures.

In 2010, notable results included an 18.3% increase in Annual Dental Visits over the course of the demonstration. Childhood Immunization Status saw a one year increase of 6.4% in Combo 2 and 8.9% in Combo 3. Measures focusing on the care of chronic conditions such as diabetes, hypertension, and asthma remained strong performers, often exceeding the national mean.

The Agency will develop or adopt additional performance measures in response to features of the Statewide Medicaid Managed Care Program to promote quality of care. When possible, established measures with available benchmark data, such as HEDIS, will be preferentially selected. Public input will be sought on the selection, adoption, and development of new and on-going measures. Managed care plans will be required to publish their results on their plan

Statewide Managed Medical Assistance Program

websites. The existing list of performance measures required for Florida health plans can be viewed on the following webpage: http://ahca.myflorida.com/medicaid/quality_mc/index.shtml. Managed care plan performance measure results are available for public viewing on the Agency's website, <http://www.floridahealthfinder.gov/>. In turn, managed care plans will be required to set performance standards for their network providers and determine continued network participation based on achievement with those standards. See Appendix A for additional information on performance measures.

In an effort to improve quality of care, the Agency adopted high standards, as defined by the NCQA National Means and Percentiles, as the performance target for each of the HEDIS measures that health plans are required to report. The strategies adopted by the Agency aim to bring the statewide level of performance in line with that performance target. To accomplish this goal, the Agency will require the development of a strategy that requires managed care plans to develop corrective action plans to address deficient scores. Failure to comply with the terms of their internally developed corrective action plans or failure to improve scores to minimal levels as set by the Agency will result in monetary sanctions. The Agency will also develop an incentive program to reward higher performing health plans. Such incentives may include additional auto-assignments each month and a financial incentive payment to encourage continual improvement.

Under the existing managed care program, plans are required to conduct Performance Improvement Projects (PIPs) in four content areas, as specified in contract: 1) clinical behavioral health; 2) cultural competence or health disparities; 3) a statewide collaborative PIP facilitated by the External Quality Review Organization (EQRO); and 4) an area of deficiency selected by the health plan. PIPs must be conducted in compliance with the Centers for Medicare and Medicaid Services protocol for conducting performance improvement projects. Under the Statewide Medicaid Managed Care program, PIPs will continue to be required, although the specific content areas may change, particularly to accommodate the addition of PIPs.

Managed care plans must participate in the activities of the EQRO, which include validation of performance measures, validation of performance improvement projects, and reviews of compliance with standards. The current EQRO contract will expire on December 31, 2012. The new contract will be selected through competitive procurement and will contain provisions related to the Statewide Medicaid Managed Care Program.

All capitated health plans, as well as fee-for-service PSNs that are capitated for transportation, must submit encounter data to the Agency that reports services provided to enrollees under the contract. Data must be reported in a HIPAA-compliant X12 format and must meet minimum quality standards for processing through the state's Medicaid Management Information System. Non-compliant health plans can be assessed a penalty for failure to submit data accurately and timely.

The Agency will utilize encounter data to conduct quality of care studies and evaluations of services provided to recipients in the Statewide Medicaid Managed Care program. As the program is developed, the Agency will work with stakeholders to identify areas of particular interest for studies, but will include, at a minimum, studies regarding access to care, appropriateness of care, and fraud and abuse.

Statewide Managed Medical Assistance Program

VII. Additional Programs

With the implementation of the Statewide Managed Medical Assistance program, the 1915(b) Managed Care Waiver will be terminated and the following programs, currently authorized under the 1915(b) Managed Care Waiver, will be transitioned to this waiver.

- A. The Healthy Start Program
- B. The Program for All Inclusive Care for Children
- C. The Comprehensive Hemophilia Program

The transitioning of these programs to this waiver will ensure the continuation of services to the eligible recipients. A description of each program follows.

A. Healthy Start Program

Background

In 1991, the Florida Legislature passed the Healthy Start Initiative and created sections 383.14 and 383.016, F.S., which provided funding for a defined set of services targeted to reduce infant mortality and morbidity. The state-only funded Healthy Start program began operations in April 1992 with the goals of reducing infant mortality, reducing the number of low birth weight infants, and improving health and developmental outcomes.

In 2001, the Agency, in collaboration with the local Healthy Start Community Coalitions and the Florida Department of Health (DOH), developed a program to increase the number and intensity of services available to women receiving Medicaid. The Healthy Start program was amended into Florida's 1915(b) Medicaid Managed Care Waiver in June 2001. The program continues to operate under Florida's 1915(b) Managed Care Waiver that was recently renewed for the period February 1, 2012 through January 31, 2014. The Agency executed a memorandum of agreement with DOH, approved by the Centers for Medicare and Medicaid Services, to administer this program. DOH subcontracts with the Healthy Start Coalitions and specified County Health Departments for the provision of the program services. The Florida Healthy Start Coalitions were established in s. 383.016, F.S., which provides for the required membership, including consumers.

In 2011, Florida legislation was passed creating s. 409.975(4), F.S., under the Statewide Managed Medical Assistance program to require the Agency to contract with an administrative services organization (ASO) representing all Healthy Start Coalitions providing care coordination services in accordance with a federal waiver and Florida law. As the program transitions under this waiver, the Agency will contract with the ASO representing all Healthy Start Coalitions for the provision of services as described below and in accordance with this waiver.

Program Description

The Healthy Start program is comprised of the following two components:

- **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,

Statewide Managed Medical Assistance Program

Healthy Start prenatal risk screening and WIC services. Recipients may disenroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources, family planning services, Medicaid coverage for the infant and the need to select a primary care physician for the infant.

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

The numbers of recipients served for State Fiscal Year 2010-2011 are as follows:

- 38,316 pregnant women,
- 9,604 infants birth to 1 year,
- 1,593 infants age 1 to 3 years, and
- MomCare through SOBRA Medicaid served 196,587.

The Healthy Start Coalitions operate under the direct oversight of Florida's Title V grantee (DOH). DOH monitor's the coalitions and specified county health departments to ensure compliance with all federal and state managed care regulations.

The Healthy Start program is available statewide for eligible Medicaid recipients. The following is a list of entities with which DOH contracts with for the provision of services as of January 2012.

Healthy Start Program List of Contracted Entities	
County	Contracting Entity
Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Marion, Putnam, Suwannee, Union	Healthy Start of North Central Florida, Inc.
Baker, Clay, Duval, Nassau, St. Johns	Northeast Florida Healthy Start Coalition, Inc.
Bay, Franklin, Gulf	Bay, Franklin, Gulf Healthy Start Coalition, Inc.
Brevard	Healthy Start Coalition of Brevard County, Inc.
Broward	Broward Healthy Start Coalition, Inc.
Calhoun, Holmes, Jackson, Liberty, Washington,	Chipola Healthy Start
Charlotte	Charlotte County Healthy Start Coalition, Inc.
Collier, Glades, Hendry, Lee	Healthy Start Coalition of Southwest Florida, Inc.
Citrus, Hernando, Lake, Sumter	Central Healthy Start, Inc.
Miami-Dade	Healthy Start Coalition of Miami-Dade, Inc.
Desoto	Desoto County Health Department
Escambia	Escambia County Healthy Start Coalition, Inc.
Flagler, Volusia	The Healthy Start Coalition of Flagler and Volusia

Statewide Managed Medical Assistance Program

Healthy Start Program List of Contracted Entities	
County	Contracting Entity
	Counties, Inc.
Gadsden	Gadsden County-Healthy Start Coalition, Inc.
Hardee, Highlands, Polk	Healthy Start Coalition of Hardee / Highlands / Polk Counties, Inc.
Hillsborough	Healthy Start Coalition of Hillsborough County, Inc.
Indian River	Indian River County Healthy Start Coalition, Inc.
Jefferson, Madison, Taylor	Healthy Start Coalition of Jefferson, Madison and Taylor Counties, Inc.
Leon, Wakulla	Capital Area Healthy Start Coalition, Inc.
Manatee	Healthy Start Coalition of Manatee County, Inc.
Martin	Martin County Healthy Start Coalition, Inc.
Monroe	Florida Keys Healthy Start Coalition, Inc.
Okaloosa, Walton	Healthy Start Community Coalition of Okaloosa and Walton Counties, Inc.
Okeechobee	Okeechobee County Family Health / Healthy Start Coalition, Inc.
Orange	Orange County Healthy Start Coalition, Inc.
Osceola	The Healthy Start Coalition of Osceola County, Inc.
Palm Beach	Healthy Start Coalition of Palm Beach County, Inc.
Pasco	Healthy Start Coalition of Pasco County, Inc.
Pinellas	Healthy Start Coalition of Pinellas County, Inc.
Santa Rosa	Healthy Start Coalition of Santa Rosa County, Inc.
Sarasota	Healthy Start Coalition of Sarasota County, Inc.
Seminole	Seminole County Health Department
St. Lucie	Healthy Start Coalition of St. Lucie County, Inc.

B. Program for All Inclusive Care for Children

Background

In October 2000, Florida was one of five states identified in federal proviso and selected by the Centers for Medicare and Medicaid Services and Children's Hospice International (CHI) to participate in developing a Program for All-Inclusive Care for Children (PACC). The intent of the PACC model is to provide pediatric palliative support services to children with life-threatening conditions from the time of diagnosis throughout the treatment phase of their illness.

In 2005, the PACC was amended into Florida's 1915(b) Managed Care Waiver as a component of the Children's Medical Services (CMS) Network with the Florida Department of Health. Section 1915(b)(3) expenditures are authorized to provide pediatric palliative care services to children who are enrolled in the CMS Network and diagnosed with potentially life-limiting conditions. The pediatric palliative care services are provided in areas of Florida where the local licensed hospice provider has a pediatric palliative care program that meets current Children's Hospice International PACC Standards and Guidelines.

Statewide Managed Medical Assistance Program

Program Description

The PACC program provides the following pediatric palliative care support services to children enrolled in the CMS Network who have been diagnosed with potentially life-limiting conditions and referred by their primary care provider (PCP). Participation in the program is voluntary.

- Support Counseling – Face-to-face support counseling for child and family unit in the home, school or hospice facility, provided by a licensed therapist with documented pediatric training and experience.
- Expressive Therapies – Music, art, and play therapies relating to the care and treatment of the child and provided by registered or board certified providers with pediatric training and experience.
- Respite Support – Inpatient respite in a licensed hospice facility or in-home respite for patients who require justified supervision and care provided by RN, LPN, or HHA with pediatric experience. This service is limited to 168 hours per year.
- Hospice Nursing Services – Assessment, pain and symptom management, and in-home nursing when the experience, skill, and knowledge of a trained pediatric hospice nurse is justified.
- Personal Care – This service is to be used when a hospice trained provider is justified and requires specialized experience, skill, and knowledge to benefit the child who is experiencing pain or emotional trauma due to their medical condition.
- Pain and Symptom Management – Consultation provided by a CMS Network approved physician with experience and training in pediatric pain and symptom management.

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

A total of 1,315 children have received PACC services since the program began operating in 2005. The number of children receiving services as of April 2012 was 485. Enrollment in the program is capped at 940 children and services are provided on a fee-for-service basis to eligible participating hospice providers.

PACC services are currently available in 48 counties of the state. CMS Network is working with local hospice programs in the additional 19 counties to develop viable pediatric palliative care programs in those counties.

CMS Network - Program for All Inclusive Care for Children	
Regions	Entity
Region 1 – Escambia, Okaloosa, Santa Rosa, Walton	Florida Department of Health
Region 2 – Bay, Franklin, Gulf, Holmes, Jackson, Washington, Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla	Florida Department of Health
Region 3 – Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Levy, Lafayette, Putnam, Suwannee, Union, Citrus, Hernando, Lake, Marion, Sumter	Florida Department of Health
Region 4 – Baker, Clay, Duval, Nassau, St. Johns, Flagler, Volusia	Florida Department of Health
Region 5 – Pasco, Pinellas.	Florida Department of Health

Statewide Managed Medical Assistance Program

CMS Network - Program for All Inclusive Care for Children	
Regions	Entity
Region 6 – Hardee, Highlands, Hillsborough, Manatee, Polk	Florida Department of Health
Region 7 – Orange, Osceola, Seminole (Brevard expansion Oct 2012)	Florida Department of Health
Region 8 – Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota	Florida Department of Health
Region 9 – Indian River, Martin, St. Lucie, Okeechobee, Palm Beach	Florida Department of Health
Region 10 – Broward	Florida Department of Health
Region 11 – Dade, Monroe	Florida Department of Health

C. Comprehensive Hemophilia Disease Management Program

Background

In 2002, Florida legislation mandated the implementation of the hemophilia disease management program. The Centers for Medicare and Medicaid Services approved the inclusion of this program initiative under Florida's 1915(b) Managed Care Waiver in May 2003 for eligible recipients who were enrolled in the FFS system or a Medicaid managed care program, excluding HMOs. The program was geographically expanded statewide on April 1, 2008, for the specified populations, and on July 12, 2012, the program was expanded to include recipients enrolled in HMOs. The program provides a specialized service whereby eligible 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 one of the two contracted vendors. In addition to product distribution, the contracted vendors provide a comprehensive disease management program to recipient enrolled in the program. The primary intent of the program is to allow for pharmaceutical management for Florida hemophiliacs, resulting in cost savings to the state.

Program Description

The Medicaid Comprehensive Hemophilia Management program operates statewide as a specialized service whereby recipients who have a diagnosis of hemophilia or von Willebrand disease and are enrolled in the fee-for-service (FFS) system, the MediPass program, FFS provider service network (PSN), capitated PSN or an HMO, are required to obtain pharmaceutical services and products related to factor replacement therapy from one of the two contracted vendors. In addition to product distribution, the program provides pharmacy benefit management, direct beneficiary contact, personalized education, enhanced monitoring, and direct support of beneficiaries in the event of hospitalization, at no additional cost to the state. Enrollees have access to a registered nurse and licensed pharmacist 24 hours a day, seven days a week. The enrollees also have access to medical care and treatment through their usual

Statewide Managed Medical Assistance Program

and customary networks, with no restrictions on services or providers, and receive pharmacy products other than those related to factor replacement therapy via the usual and customary networks without restriction, as well.

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

As of July 2012, there were 209 recipients enrolled in the statewide program.

Statewide Managed Medical Assistance Program

VIII. Budget Neutrality

Budget Neutrality Overview

The revised Budget Neutrality for Florida's pending Managed Medical Assistance (MMA) amendment to the 1115 Medicaid Reform Waiver is based on the expansion of specific recipient groups who are not currently eligible for enrollment in the waiver. These new populations have been assigned into two of the three established Medicaid Eligibility Groups (MEG) defined for the current 1115 Medicaid Reform Waiver:

MEG #1 – SSI Related

MEG #2 – Children and Families

It should be noted that for MEG 3, the Low Income Pool (LIP) program, there is no specific eligibility group and no per capita measurement. Distributions of funds are made from the LIP program to a variety of Provider Access Systems.

With the MMA amendment populations' MEG assignments, the budget neutrality historical trends were updated to reflect the expanded case months and costs resulting in new projected PMPMs. The MMA amendment's historical trend covers Demonstration Year (DY) 3 – DY6 (SFY 2008-09 through SFY 2011-12). The MMA amendment's projected years cover DY9-DY11 (SFY 2014-15 through SFY 2016-17).

Transition of 1915(b) Managed Care Programs:

As noted under Section VII, the Healthy Start program, PACC and the Comprehensive Hemophilia Management program that currently operate under Florida's 1915(b) Managed Care Waiver will transition to this waiver. The Healthy Start and PACC program cost are defined as costs not otherwise matchable (CNOM) and these service costs will be funded from the MMA amendment's budget neutrality cost savings. For the Comprehensive Hemophilia Management program, the projected drug cost savings have been factored into the MMA amendment budget neutrality calculations.

Historic Trends Methodology

The first task towards updating Budget Neutrality for the MMA amendment was to identify the new eligible case months to be covered in the amendment. Florida law provides the Medicaid recipient populations who are eligible for the MMA program. This listing identifies those recipient eligibility and claim history factors that define a recipient's enrollment status under the MMA program as mandatory, voluntary or excluded. Refer to Section III of this document for the eligible and excluded populations for the MMA program.

A data algorithm was then constructed utilizing both Medicaid recipient eligibility and claims history. This algorithm was applied to all Medicaid recipient case months for the historical Demonstration Years (DY3-DY6). Each case month was designated as either mandatory, voluntary or excluded. For the MMA amendment Budget Neutrality calculations, only the mandatory population is included. Within this mandatory group, Medically Needy and Title XXI MediKid recipients are excluded from the calculations. The state is utilizing a "what if" model by applying the new MMA mandatory populations' eligibility criteria to the historical case months to identify what recipient months would have been enrolled if the MMA amendment had existed during those years. This provides a basis for generating the historic trend rates necessary to complete the Federal CMS Budget Neutrality template projections.

Statewide Managed Medical Assistance Program

The resulting eligibility database is then cross-referenced with the current 1115 Medicaid Reform Waiver caseload for these same demonstration years. For CMS 64 reporting purposes, the state maintains an eligibility file that identifies the recipient case months that are eligible on a statewide basis for the current 1115 Medicaid Reform Waiver. These case month figures are identified in the Florida 1115 Medicaid Reform Waiver quarterly and annual progress reports. The resulting cross-referenced database can identify those specific historical case months that were not eligible under the current 1115 Medicaid Reform Waiver, but would have been eligible under the MMA amendment. With the MMA amendment case months identified, these recipient identification numbers (IDs) and eligible months are processed through Medicaid claim history to identify and aggregate their costs. The remaining task is to assign the MMA amendment case months and the costs into MEG 1 or MEG 2. This is done by recipient eligibility codes following the same principle of MEG 1 being SSI related and MEG 2 being children and families.

Table A: Amendment Impact on Trends

Table A provides the results from the above database exercise. Table A objective is to quantify the overall case month trends that will result from the inclusion of the MMA expansion and to quantify what the MMA amendment impact will be on case month mix and costs. Table A has three segments:

- The first segment identifies the caseload for the current 1115 Medicaid Reform Waiver. These annual case month figures are found in the 1115 Medicaid Reform Fourth Quarter Report for DY6 (see Table 31 on pages 50-51). The PMPMs are the PCCM Targets utilized for the current 1115 Medicaid Reform Waiver WOW calculations.
- The second segment identifies the annual MMA new population case months that would be covered under the MMA amendment along with their WOW costs.
- The third segment is an aggregate of both the current 1115 Medicaid Reform Waiver and the MMA new population figures. The resulting aggregate totals are then inserted into the Budget Neutrality Historic Data template for DY3-DY6 (Table B).

The core services to be covered under the state's 1915(b)(c) Managed Care Long-Term-Care (LTC) waiver are excluded from both the current 1115 Medicaid Reform Waiver and the MMA amendment Table A cost figures. These core services are nursing home care and home and community based services (Aged/Disabled Waiver, Assisted Living Waiver, Nursing Home Diversion Waiver and Channeling Waiver). These home and community based services (HCBS) costs are excluded from this MMA amendment's Budget Neutrality. In addition, the excluded services from the 1115 Medicaid Reform Waiver are also removed from the new MMA population costs. This allows for a more consistent cost base when comparing these two populations.

MEG 1 Expanded Population Impact

The 1115 Medicaid Reform Waiver MEG 1 population will be significantly increased by the new MMA populations. As shown in Table A, the addition of the new MEG 1 eligibles doubles the size of the current 1115 Medicaid Reform MEG 1 case months. In addition, the MMA amendment MEG 1 population has a substantially lower PMPM cost (approximately 22% of the current MEG 1 PCCM targets). Under the 1115 Medicaid Reform Waiver, dual eligible (Medicaid/Medicare) recipients are not mandatorily enrolled in managed care plans, but can voluntarily enroll. With the MMA amendment, dual eligibles will be mandatorily enrolled in

Statewide Managed Medical Assistance Program

managed care plans. These LTC service costs (nursing home care and HCBS waivers) represent approximately 88% of all the dual eligibles' Medicaid costs, with nursing home costs alone being 76%.

MEG 2 Expanded Population Impact

The current 1115 Medicaid Reform Waiver MEG 2 population will be impacted primarily by the new MMA population to include adoption subsidy and foster care children and SOBRA pregnant women. These recipient populations represent 64% of the new expanded MEG 2 case months, with SOBRA pregnant women being 44% and adoption/foster care children being 20%. The PMPM for these new populations are significantly higher than the current MEG 2 PCCM targets. The overall new MEG 2 PMPMs are identified in Table A and are approximately twice as much as the current PCCM targets. In particular, the SOBRA pregnant women population has a SFY 2010-11 PMPM of \$777.60 compared to the current 1115 Medicaid Reform Waiver MEG 2 PCCM target of \$271.39.

Table B: Historic Data Trends

This Federal CMS template utilizes the case month and expenditures identified in Table A. These figures calculate the case month trend rate for both the Without Waiver (WOW) and With Waiver (WW) projections. The template also calculates the costs per eligible trend rate for the WOW projection.

Table C: Without Waiver Projection

Based on the historic trend rates and Months of Aging, the WOW case months, expenditures and costs per eligible are projected for DY9-DY11. The 36 Months of Aging reflects the mid-point of DY6 through the mid-point of DY9.

Table D: With Waiver Projection

Both the WW and WOW utilize the same case month projection. The first step for calculating the WW PMPM is a continuation of the projection from the previous Budget Neutrality submitted in the MMA amendment on August 1, 2011. This previous projection covered DY6-DY8. The same August 1, 2011 projection equation is now extended to cover DY9-DY11. Table E is included to show the extension of the previously submitted August 1, 2011 WW projection. Table E projected PMPMs are identified in Table D in the row labeled: Total Cost Per Eligible (Continuation of August 1, 2011 Projections).

The second component for calculating the WW PMPM is a weighted adjustment factor to account for the new case month mix resulting from the MMA amendment. At the bottom of Table A, there are a set of MEG 1-MEG 2 annual figures that are a ratio of the combined programs' PMPMs to the current 1115 Medicaid Reform Waiver PMPMs. These ratios are averaged over the four years. This weighted PMPM adjustment factor is identified as 55.18% for MEG 1 and 109.55% for MEG 2. These weighted ratios provide a method for adjusting the current 1115 Medicaid Reform Waiver WW projected PMPMs to account for the impact of the new MMA populations. These adjustment factors are applied to the WW projections in Table D.

An adjustment is also added to Table D to identify projected cost savings that will occur in the WW projected years (DY9-DY11). This cost savings will result from the operation of the Comprehensive Hemophilia Management program vendor contracts that went into effect July 1,

Statewide Managed Medical Assistance Program

2012 of DY7. The Table D cost savings figures identify the 25% drug price discount for the specified hemophilia related drugs covered in these vendors' contracts. These are cost savings that will not be realized in the WOW projections. Table F identifies the historic trends and projected the saving calculations of the Comprehensive Hemophilia Management program.

Table G and H: Summary of CNOM Impact

Tables G and H are provided to demonstrate how the two CNOM programs' projected expenditures for DY9-DY11 were calculated. The Budget Neutrality summary identifies that the MMA amendment savings will be adequate to sustain these CNOM programs.

Budget Neutrality Summary

An overall Budget Neutrality summary is provided at the bottom of Table D. A specific table reference is provided to identify where each of the individual figures is calculated. The table calculations presented herein result in a determination that the MMA amendment will be Budget Neutral.

Statewide Managed Medical Assistance Program

Appendix A Performance Measures and Outcomes

The following is an overview of select measures regarding the impact of the demonstration. Performance Measures

Medicaid Reform health plans are required to submit an extensive list of quality indicators (HEDIS and HEDIS-like) that measure plan performance on both preventive and illness care. Select successes from the 2010 submission include:

- Annual Dental Visit, a measure that is particularly challenging for most health plans, achieved an 18.2% increase over the course of the demonstration with a 4.9% increase over the past year.
- Childhood Immunization Status saw a one year increase of 6.4% in Combo 2 and 8.9% in Combo 3.
- Measures focusing on the care of chronic conditions such as diabetes, hypertension, and asthma remained strong performers, often exceeding the national mean.
- Strong performance continued for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life.

In addition to requiring the calculation and submission of the performance measures, the Agency requires that health plans operate continuous quality improvement programs. The measures submitted this year are subject to new contract terms that require formal interventions for all measures scoring below the 50th national percentile. If the interventions fail to improve the measures, sanctions may be assessed in response to the 2011 performance measure submission.

Satisfaction

The key findings of the patient satisfaction survey results are highlighted below.

Key Findings

- Enrollee satisfaction for most indicators remained stable or increased slightly (including specialty care ratings, emergency room visits, communication, courtesy and respect of staff) and showed little if any change from benchmark measures taken prior to demonstration through the first three years of implementation.
- In some areas, statistically significant changes were observed. There was an upward change in satisfaction with recipient's personal doctor and with getting needed care.
- This upswing indicates an increase in satisfaction at the point of care.

Appendix B

Florida Medicaid Program

1. The Florida Medicaid Program

In 1965, the federal Social Security Act was amended to establish two major national health care programs: Title XVIII (Medicare) and Title XIX (Medicaid). If a State chooses to participate in the Medicaid program, the State is then obligated to provide services to all individuals who are eligible for the program. Federal Medicaid laws and regulations mandate certain benefits for certain populations and States must administer their programs in accordance with federal regulations and laws.

The State operates the program under a State plan approved by the federal Centers for Medicare and Medicaid Services, which can be thought of as a contract. To participate, States are required to cover certain mandatory populations and services, while federal matching funds are available if a State chooses to cover other optional populations and services. A State cannot limit the number of people its Medicaid program will serve, and cannot limit provision of medically necessary covered services to enrollees based on budgetary constraints. The Florida Medicaid program currently serves more than 3.1 million recipients and total appropriation for the program for State fiscal year 2011-2012 is \$21.2 billion. Medicaid covers low-income pregnant women, children and disabled adults.

2. Florida Medicaid Delivery Systems and Program Enrollment

Since its inception, the Florida Medicaid program has evolved into a complex model with a collection of programs, waivers, and delivery systems through which recipients receive care. These delivery systems for covered medical services include FFS, primary care case management (offered in Florida through the MediPass program), or managed care under a capitated HMO or a FFS or capitated PSN.

The Florida program was established as a FFS program in 1970, and the first Medicaid managed care plan was established in 1984. MediPass, the primary care case management (PCCM) program, was established in 1991 and several other changes have also been implemented in care management and delivery in the last two decades.

The implementation of the Statewide Medicaid Managed Care System will serve to streamline these varied systems into a more comprehensive program and is anticipated to create an integrated delivery system available throughout the State.

Fee-For-Service

The FFS system is operated under the federally approved State plan. The FFS system serves those Medicaid recipients who are not eligible for or enrolled in a managed care program. As a result of the passage of HB 7107, the vast majority of enrollees will have to select a plan. As of June 1, 2011, there were over 939,000 recipients receiving services through the FFS system. These recipients include those who are eligible for limited or diagnosis specific services such as services related to pregnancy, or a diagnosis of breast or cervical cancer, the dual eligible population (those who are eligible for both Medicare and Medicaid), the Medically Needy populations, individuals in institutional settings, and those who are newly eligible for Medicaid but who have not yet enrolled in a health plan. While most individuals will enroll in a contracted

plan under the Statewide Managed Medical Assistance program, the State will continue to maintain a FFS program to provide services to excluded individuals and to recipients newly eligible for Medicaid who are in their choice period that occurs before enrolling into a contracted plan.

MediPass is the Florida Medicaid primary care case management program. The State established the MediPass program in 1991 and expanded the program Statewide in 1996. MediPass is operational in 62 counties outside of the demonstration counties (Medicaid Reform). MediPass providers (physicians, ARNPs, and physician assistants) are paid a \$2.00 monthly case management fee. Medicaid pays for services provided to MediPass members on a FFS basis. As of June 1, 2011, there were 611,864 recipients receiving services through the MediPass program. Under the Statewide Managed Medical Assistance program, individuals currently enrolled in MediPass will be required to select and enroll in a plan.

Managed Care

The managed care delivery systems, including capitated plans and FFS PSNs, are currently operated under two waivers: (1) The 1915(b) Managed Care Waiver or (2) the 1115 Medicaid Managed Care Pilot (Reform) Waiver. The Reform waiver is operational in five counties, including Baker, Broward, Clay, Nassau and Duval counties.

A PSN is defined in section 409.912 (4)(d), Florida Statutes, as an integrated health care delivery system owned and operated by a health care provider, or group of affiliated health care providers which provides a substantial proportion of the health care items and services under a contract directly through the provider or group of affiliated providers. PSNs are reimbursed on a FFS basis, with shared savings, or prepaid (capitated) basis. As of June 1, 2011, there were six PSNs serving 221,853 recipients in both Reform and non-Reform counties. Under the Statewide Managed Care program, PSNs will be eligible plans to participate in both the Long Term Care Managed Care program and the Managed Medical Assistance Program. Specifically, the State is required to contract with at least one PSN, in each region, for both program components, if a qualified PSN submits a response to the invitation to negotiate in the region. As a result, PSN contracting and contract monitoring will increase with the potential of more than 22 PSN contracts.

A HMO is an entity licensed under Chapter 641, Florida Statutes. The State contracts with HMOs on a prepaid fixed monthly rate per member (e.g., capitation rate) for which the HMOs assume all risk for providing covered services to their enrollees. As of June 1, 2011, there were 19 HMOs serving 1,135,892 recipients in both Reform and non-Reform counties. Under the Statewide Medicaid Managed Care program, HMOs will be eligible plans to participate in both the Long Term Care Managed Care program and the Statewide Managed Medical Assistance program. HMO contracting and contract monitoring is expected to increase significantly, with the potential for 30-53 contracts for Statewide Managed Medical Assistance program and an additional 30-53 contracts for the Long Term Care program.

a) Demographics of Enrollment – By Delivery System

In general, most children and adults who are fully eligible for Medicaid are currently required to enroll in some form of managed care to receive medical services. For those in counties operating under Florida's 1915(b) Managed Care Waiver, this means they must enroll in an available managed care program which currently includes either a capitated HMO, a PSN, or the MediPass program. For those in counties operating under the 1115 Research and

Demonstration Waiver (Baker, Broward, Clay, Duval, and Nassau), this means they must be enrolled in either an HMO or a PSN. MediPass is not an option for demonstration enrollees.

The following Medicaid recipients are currently excluded from enrolling in a managed care program: Medically Needy recipients, aliens receiving emergency assistance, recipients enrolled through the breast and cervical cancer program, recipients enrolled in the family planning waiver, recipients in institutional settings, recipients receiving hospice services, and recipients residing in facilities operated by the Department of Juvenile Justice and the Department of Children and Families (including the Family Safety and preservation program and substance abuse and mental health residential treatment programs).

Elderly recipients who reside in a nursing home are not currently required to enroll in managed care to receive medical services.

b) Demographics of Enrollment-By Eligibility Type

In general, Medicaid enrollment can be broadly categorized as being made up of three main groups:

- The TANF population (Temporary Assistance for Needy Families), which generally includes low income children and their families,
- The SSI population (Supplemental Security Income), which generally includes the disabled, and
- The dually eligible population, which includes the disabled elderly and the poor elderly who also receive Medicare benefits who are also eligible for Medicaid.

The TANF population is most impacted by the economy, and TANF enrollment makes up a majority of program enrollment and thus follows general enrollment trends. Overall, Medicaid enrollment in Florida is estimated to have increased by more than 44% from the 2005-2006 fiscal year through the 2011-2012 fiscal year. TANF enrollment will have increased, during that same period, by 37%; SSI enrollment by 23% and Dual enrollment by 37%. Table 1 provides an overview of Medicaid eligibility for these groups during this period.

Table 1: Average Monthly Florida Medicaid Enrollment – By Eligibility Group

Average Monthly Florida Medicaid Enrollment - Breakout of SSI and TANF				
Fiscal Year	TANF Enrollment	SSI Enrollment	Dual Eligibles	Total Enrollment
FY 2005-06	1,256,264	502,395	482,624	2,204,481
FY 2006-07	1,165,000	519,000	486,962	2,112,000
FY 2007-08	1,131,574	531,433	498,870	2,148,705
FY 2008-09	1,272,284	551,405	531,246	2,398,613
FY 2009-10	1,500,811	574,345	569,631	2,718,524
FY 2010-11	1,633,066	598,381	616,355	2,937,573
FY 2011-12	1,726,785	621,300	664,057	3,191,710

TANF Source: Medicaid Services Eligibility Subsystem Reports. Caseload includes TANF and SOBRA Children

SSI and Total Enrollment Source: Medicaid Services Eligibility Subsystem Reports.

c) Florida Medicaid Managed Care Penetration

Currently, approximately 43% of the total Medicaid population is enrolled in either a HMO or a PSN. It should be noted that the “total Medicaid population” includes individuals currently ineligible for enrollment into managed care. Table 2 on the following page provides Florida Medicaid enrollment by managed care delivery model as of June 1, 2011.

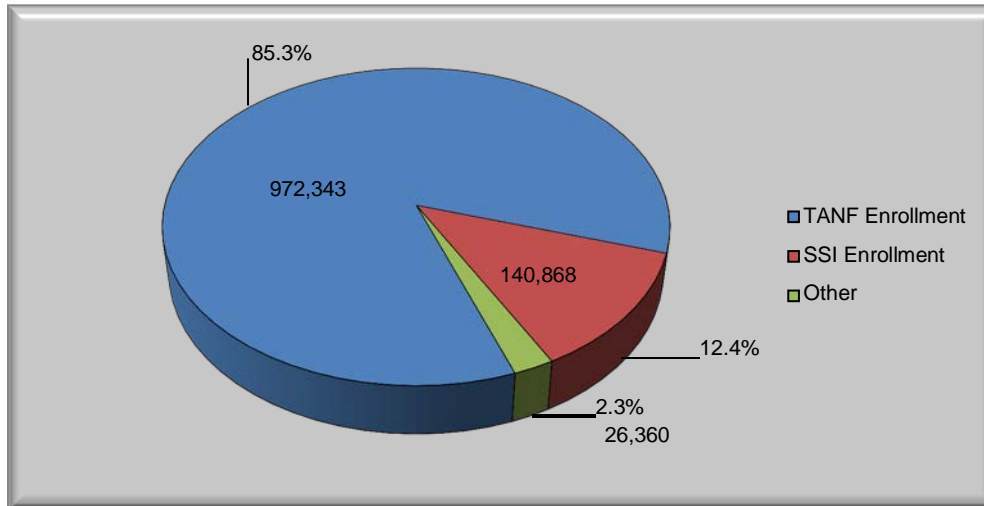
Table 2: Florida Counties with Managed Care Health Plans – June 1, 2011

Florida Counties with Managed Care Plans – By Plan Type – June 1, 2011		
Plan Type	Number of Florida Counties	Total Enrollment
Capitated PSN	29	79,271
Capitated Non-Reform HMO	35	981,159
FFS PSN	6	142,583
Capitated Reform HMO	5	154,733
	Total unduplicated Counties: 48	Total plan enrollment: 1,357,746

Florida Counties with Managed Care Plans (HMO and PSN) – June 1, 2011	
Total Unduplicated Counties with Health Plans Currently In Operation	48 Counties
Total Unduplicated Counties with No Health Plans Currently in Operation	19 Counties

Figure 3 on the following page illustrates the distribution of health plans by Florida County. Note: Although PACE plans are not included for the purposes of this figure, they are in operation in Lee, Miami-Dade, Pinellas, and Charlotte counties.

Figure 4: June 1, 2011 Medicaid Managed Care Enrollment – By Eligibility Type



It is anticipated that the number and proportion of SSI enrollees in managed care will increase once the Statewide Medicaid Managed Care program is fully implemented. The TANF population will look very similar to the recent trend with a majority enrolled in managed care. With the addition of SSI populations and the dually eligible population to managed care, a greater proportion of the overall managed care population will consist of SSI and dual eligibles in the future.

Appendix C

Children's Medical Services Network

The Children's Medical Services (CMS) Network

Purpose of the CMS Network

The CMS Network is Florida's Title V Program for children with special health care needs. It is a State program located in the Department of Health and operates under Chapter 391, Florida Statutes. Its purpose is to develop and procure a comprehensive and coordinated Statewide system of medical and health-related services for children with special health care needs. The eligible children are defined as those children under age 21 whose serious or chronic physical, developmental, behavioral or emotional conditions require extensive preventive and maintenance care beyond that required by typically healthy children, Section 391.02 FS.

Structure of the CMS Network

The State program is comprised of a central office and 22 local offices organized in eight regions. The functions of the central office are:

- Contract management
- Pharmacy Benefit Management (Title XXI only)
- Policy development
- Quality assurance and development of program standards
- Selection of regional and Statewide programs and provider networks
- Centralized and automated credentialing
- Centralized claims processing
- Financial management
- Data analysis
- Maintenance of technology systems
- Enrollment file management
- Training and technical assistance
- Statewide clinical review and recommendation teams
 - Physician peer review
 - Drug utilization review
 - Medical procedures and equipment
- HEDIS reporting and evaluation

The functions of the local offices are:

- Clinical eligibility determination (financial eligibility determination is conducted through Florida's systems for Medicaid and CHIP eligibility)
- Recruitment and retention of providers (over 11,000 providers, 110 facilities, home health agencies, etc.)
- Utilization management
- Care coordination (nurses and social workers)
- Transition planning
- Staffing specialty satellite or telemedicine clinics
- Member services and enrollment assistance (selection of primary care provider)

- Outreach and activities to encourage continued participation in the program
- Family to family support

Clinical and Financial Eligibility

Children are screened clinically using a tool that addresses a combination of diagnoses, functional status and health care needs, and utilization. The child must have a medical, behavioral, or developmental health condition that has lasted or is expected to last at least 12 months, or be in foster care. CMS Network is also the lead agency for Part C of the Individuals with Disabilities Education Act. Any infant and toddler under the age of 3 who meets the developmental criteria for this program are clinically eligible for the CMS Network.

Children who qualify for Title XIX or XXI are financially eligible for the CMS Network. Financial eligibility is determined through the Florida KidCare application or Medicaid financial determination processes. The KidCare application and Medicaid Choice Counseling have screening questions that trigger referral to CMS Network for clinical screening. If special health care needs are identified or suspected the family is provided with the necessary information to contact CMS Network for further information and clinical eligibility screening. There is no requirement that the family must contact CMS Network and there is no mandatory assignment for children with special health care needs. Once eligibility is determined the family must select CMS Network and enroll through the Agency for Health Care Administration Choice Counseling system.

Benefits

A multidisciplinary approach to the provision of services is important and required to meet the needs of both the child and the family.

The continuum of care includes prevention and early intervention programs, primary care, medical and therapeutic specialty care, and long term care for medically complex or fragile children and high-risk pregnant women. Long term care services include medical day care, medical foster care, nursing home care and in-home care.

Children in the CMS Network receive, at a minimum, the Medicaid benefit package and care coordination. Care coordination is provided by a CMS Network Nurse Care Coordinator whose role is that of integrating all of the elements of each child's life related to his/her special health care needs, in coordination with the primary care physician and the family. The Care Coordinator is a critical link in obtaining the appropriate clinical care and services, social and emotional development of the child within the context of their family, school and community, and is integral for the development of a true medical home environment for the child and family.

State law authorizes CMS Network to offer additional benefits for early intervention services, respite services, genetic testing, genetic and nutritional counseling and parent support services, if such services are determined to be medically necessary and are subject to the availability of funds. These services are not covered by the Florida Medicaid program, but are covered through funds available in the CMS Network (general revenue, maternal and child health block grant funds, etc.).

Provider Requirements and Structure

CMS Network uses NCQA criteria as its baseline for its credentialing activities. An on-line application process is available to providers who are interested in participating in the CMS

Network. Physician providers must be licensed in Florida and board-certified.

CMS Network focuses on the medical home in the child's community. In 12 areas of the State CMS Network contracts with non-profit corporations to recruit primary care providers and offer EPSDT case management. CMS Network also recruits available specialties and supports in the communities, including dental care, mental and behavioral health care, pediatric palliative care and transition from pediatrics to adult care. However, CMS Network selects and approves regional programs based on national or state standards. These include centers focusing on hematology/oncology, diabetes/endocrine issues, craniofacial/cleft lip and cleft palate, cardiac, pulmonary, Children's Comprehensive Kidney Failure Center, sickle cell, brain and spinal cord injury, medical foster care, pediatric HIV-AIDS, genetics, transplantation, regional perinatal intensive care centers, etc.

Services are offered in hospitals, outpatient settings and community based settings, including a child's home based on the nature of the service. Services are prior authorized by nurses and, as appropriate, by the CMS Network Medical Director.

If a child needs a service that is not available in the community, the Statewide network of providers is available to the child. In addition, children are evaluated for out-of-state services when such services may not be available in Florida.

CMS Network and Medicaid Reform

Under Medicaid reform, CMS Network has been designated as a specialty plan for children with special health care needs. In the Medicaid reform counties, the CMS Network central office contracts with local Integrated Care Systems (ICS) who work in partnership with the local CMS Network offices to provide for the needs of enrolled children. The responsibilities of each entity are delineated in a formal care coordination plan.

The local CMS Network office is responsible for clinical eligibility determination and annual redetermination, care plan development, care coordination with the Care Coordinator serving as the primary liaison at the local level between the CMS Network program, the ICS, the family and the child's service providers, health education, social work services and counseling, family support and transition support. Specialty clinics and the use of telemedicine are utilized as necessary to meet the multi-disciplinary and multi-specialty needs of enrolled children.

The ICS is responsible for physician recruitment, network management, credentialing and/or contracting, provider services, authorization for services, claims payment, utilization review, quality management, complaint and grievance resolution, behavioral health services and transportation in addition to the other Medicaid State Plan services.

Additionally, the local CMS Network offices and the ICSs have a multi-disciplinary review process to ensure that the child is receiving the most appropriate, medically necessary services based upon their individual needs.

The program operates through a shared savings arrangement. CMS Network has consistently demonstrated savings through its reform arrangements and meets or exceeds HEDIS measures and patient satisfaction measures.

In areas where there is not a current ICS relationship, the CMS Network local office is responsible for all program components.

Evaluation

CMS Network consistently meets or exceeds HEDIS child health measures used by Medicaid for this population. In addition, CMS Network has used CAHPS since 1998 to evaluate family satisfaction and other measures. There is a high degree of satisfaction with the CMS Network and, as mentioned above, CMS Network has continued to demonstrate savings.

Appendix D

Plan Transition Process

The State's mission is to ensure quality care is provided to Florida's residents. The primary goal of the transition to the new contracted plan will be to ensure continuity of care for all affected enrollees. The following is a summary of the processes and requirements established in state law that will enable the State to reach this goal.

DETAILED PLAN TRANSITION PROCESSES

The State will carefully plan the transition of the affected enrollees into other plan. To ensure continuity of care of affected enrollees upon enrollment in a new plan and to assist them through the choice process, the State follows a multi-layered approach:

- Assessing the capacity of the new contracted plans to ensure all impacted enrollees have access to quality care.
- Requiring the existing health plan to provide a listing of members' primary care providers (PCPs) to facilitate the transition into a new contracted plan that also includes the PCP.
- Requiring the existing health plan to identify any members in active behavioral health care to facilitate a written care coordination plan.
- Comparing provider networks to ensure continuity of care and continued availability of current primary care and behavioral health providers with the new contracted plan.
- Working with the new contracted plans and the State's or State's designated contractor to create staggered transition dates will ensure that the number of recipients being transitioned occurred in an organized manner.
- Working with the new contracted plans, the State or the State's designated contractor, local area staff, and advocacy groups will ensure appropriate and timely notice to enrollees, including the development and release of flyers to locations and providers frequented by impacted enrollees to help ensure recipients understand the changes that are occurring.
- Working with the new contracted plans to supply PCP and service information will ensure continuity of care and minimize disruption to the recipients, including reviewing the existing plan's provider network to determine which PCPs are available in the new contracted plans.
- Assisting PCPs unique to the existing plan through the Medicaid provider enrollment process to facilitate the PCPs enrollment in new contracted plan networks.
- Conducting weekly calls with the Florida Medicaid Area Offices, Medicaid Contract Management, and the State's or State's designated contractor will ensure all issues are resolved in a timely manner.

The State's or State's designated will station choice counselors in the Medicaid Area Offices to assist enrollees in their choice of a new contracted plan. These choice counselors may conduct special face-to-face choice counseling sessions specifically geared to transition enrollees.

ENROLLEE NOTIFICATIONS

For the transition to the new contract plans and if a contracted plan leaves a region early, enrollees will be given written notification of the change and an opportunity to select a new contracted plan. The member notices will include the date on which the existing health plan will no longer participate in the State's Medicaid program and instructions on contacting the State's or State's designated contractor's toll free help line to obtain information on enrollment options and to request a change to a new contracted plan.

If an affected enrollee selects a new contracted plan 30 days prior to transition date, the State will send a letter confirming the effective date of enrollment into the new contracted plan.

If the affected enrollee doesn't select a new contracted plan 30 days prior to transition date, the State will send a letter to the enrollee with information on the new plan enrollment and how to contact the State's or State's designated contractor's toll free help line to request a change to another contracted plan prior to the enrollment effective date.

All impacted beneficiaries will be given 90 days after enrollment in the new contracted plan to select another contracted plan without cause.

OVERVIEW OF CONTRACTED PLAN TRANSITION REQUIREMENTS

When a contracted plan decides to withdraw from a demonstration county, the plan will be required to provide written notice to the State at least 180 days prior to the anticipated effective date and must cease community outreach activities. The contracted plan will be required to work with the State to ensure a smooth transition for enrollees. The State's model contract will allow the State to extend the termination date depending on the number of plan enrollees affected. In addition, 60 days prior to the withdrawal date, the State will halt enrollment of new members into the plan.

By contract, to ensure continuity of care, health plans will be contractually required to honor prior authorization of ongoing covered services for a period of thirty (30) calendar days after the effective date of enrollment, or until the enrollee's PCP reviews the enrollee's treatment plan, whichever comes first. Prearranged covered services may include provider appointments, surgeries, and prescriptions. For covered behavioral health services, this policy will be extended for up to three months.

To ensure stability, the State will impose new penalties for the contracted plans that reduce enrollment levels or leave a region before the end of the contract term. Specifically, plans will be required to reimburse the State for the cost of enrollment changes and other transition activities associated with the plan action. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks will be required to pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another contracted plan, whichever occurs first. In addition to payment of costs, all other plans will be required to pay a penalty of 25% of the minimum surplus requirement pursuant to state law. The contracted plans will be required to provide at least 180 days notice to the State before withdrawing from a region. If a contracted plan leaves a region before the end of the contract term, the State will be required to terminate all contracts with that plan in other regions.

For plans that are awarded an “additional contract”, to ensure plan participation in Regions 1 and 2, the plan will be subject to penalties pursuant to state law for activities in Region 1 or Region 2, The additional contract will automatically be terminated 180 days after the imposition of the penalties. The plan will be required to reimburse the State for the cost of enrollment changes and other transition activities.



State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

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

Mission Statement
Better Healthcare for All Floridians.