Attachment I
Amendment Request #1
Overview

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Purpose: The State is requesting an amendment to the Florida Medicaid Reform 1115 demonstration (Project # 11-W-00206/4) to implement certain programmatic aspects of the statewide managed medical assistance program. It is important to note that the State is seeking an amendment to the current 1115 Research and Demonstration Waiver as many of the federal authorities required to implement the program have been granted to the State. However, the new program improves upon the current reform program and upon implementation the reform program will sunset.

2011 Legislation

The Agency for Health Care Administration (the Agency) is designated as the single state agency responsible for the administration of the Florida Medicaid Program. The Agency delegates certain functions to other state agencies, including the Department of Children and Families, the Department of Elder Affairs and the Agency for Persons with Disabilities. The Florida Medicaid program currently serves more than 3 million Medicaid recipients and has a total appropriation for state fiscal year 2011-12 of $21.2 billion.

During the 2011 Florida Legislative session, the Florida Legislature passed and Governor Scott signed legislation to expand managed care in the Florida Medicaid program. This legislation included CS/HB 7107 (Chapter 2011-134, Laws of Florida). CS/HB 7107, in part, creates a statewide managed medical assistance program which will provide primary and acute medical assistance and related services using a managed care model. The legislation reads as follows:

- Section 409.964, Florida Statutes, provides for the Managed care program; state plan; waivers. “The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall submit any state plan amendments, new waiver requests, or requests for extensions or expansions for existing waivers, needed to implement the managed care program by August 1, 2011.”

The newly enacted legislation requires that the Agency submit any state plan amendments or waivers requests by August 1, 2011 (see provision above) to the Centers for Medicare and Medicaid Services (CMS). The legislation also provides that implementation of this program begin by January 1, 2013, with full implementation required by October 1, 2014.

As a result, the Agency is seeking an amendment to the current 1115 research and demonstration waiver to implement the program. The following changes are requested:

- Request to expand geographic operation statewide.
- Request to include previously voluntary groups as mandatory (Medicare dual eligibles, children with chronic conditions, children in foster care and adoption subsidy).
- Update programmatic operations and safeguards.

Summary of the Statewide Managed Medical Assistance Program

The following is a summary of the key components of the statewide managed medical assistance program as provided for in CS/HB 7107.

Statewide Managed Medical Assistance Program Regions

The new legislation establishes 11 regions throughout the state of Florida, and outlines the number of plans authorized to provide services in each region. Table 1 on the following page provides a list of the counties by the 11 regions.

Table 1		
Region	**Counties**	**Anticipated Implementation Date**
Region 1:	Escambia, Okaloosa, Santa Rosa and Walton	TBD June 2013- October 2014
Region 2:	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington	
Region 3:	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union	
Region 4:	Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia	
Region 5:	Pasco and Pinellas	
Region 6:	Hardee, Highlands, Hillsborough, Manatee and Polk	
Region 7:	Brevard, Orange, Osceola and Seminole	
Region 8:	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	
Region 9:	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie	
Region 10:	Broward	
Region 11:	Miami-Dade and Monroe	

Procurement Methods of Managed Care Plans

The Agency will competitively procure health plans (managed care organizations and fee-for-service provider service networks) to provide services in each of the 11 regions. The Agency will begin implementation of the statewide managed medical assistance program beginning January 1, 2013, with full program implementation by October 1, 2014. Once the Agency has issued the procurement and awarded the contracts, the Agency will provide a detailed transition plan based on plan readiness and capacity.

The legislation establishes criteria for preference in reviewing ITN respondents, including accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body; experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations; availability and accessibility of primary care and specialty physicians in the provider network; establishment of community partnerships with providers that create opportunities for reinvestment in community-based services; commitment to quality improvement; provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes; and documentation of policies for preventing fraud and abuse. The Agency is directed to enter into five-year health plan contracts with selected vendors. The Agency may not renew the contracts, and may extend the term of the contact only in order to cover any delays in transitioning to a new plan, but the contract may not be renewed.

Number of Plans Per Region

The Agency will procure a specified number of managed medical assistance plans per region. A minimum and maximum number of plans is specified, along with the requirement that, of the total contracts awarded per region, at least one plan shall be a provider service network if any provider service networks submit a responsive bid. Issuance of the procurement will provide for a choice of plans, as well as, market stability as the Agency will seek to enter into five year contracts. As noted in Table 2 and the map on the following page, there will be a minimum of two plans choices in each of the 11 regions. To the extent that there are fewer than two plan choices in an area, the Agency will issue a procurement to obtain a second plan and meet the federal requirements regarding choice until two plans are available.

Table 2

Managed Medical Assistance: Plans Per Region

	Min # of Plans	Max # of Plans	# of PSNs	Children's Medical Services Network
Region 1	2	2	1	The CMS Network will operate statewide
Region 2	2	2	1	
Region 3	3	5	1	
Region 4	3	5	1	
Region 5	2	4	1	
Region 6	4	7	1	
Region 7	3	6	1	
Region 8	2	4	1	
Region 9	2	4	1	
Region 10	2	4	1	
Region 11	5	10	1	

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.

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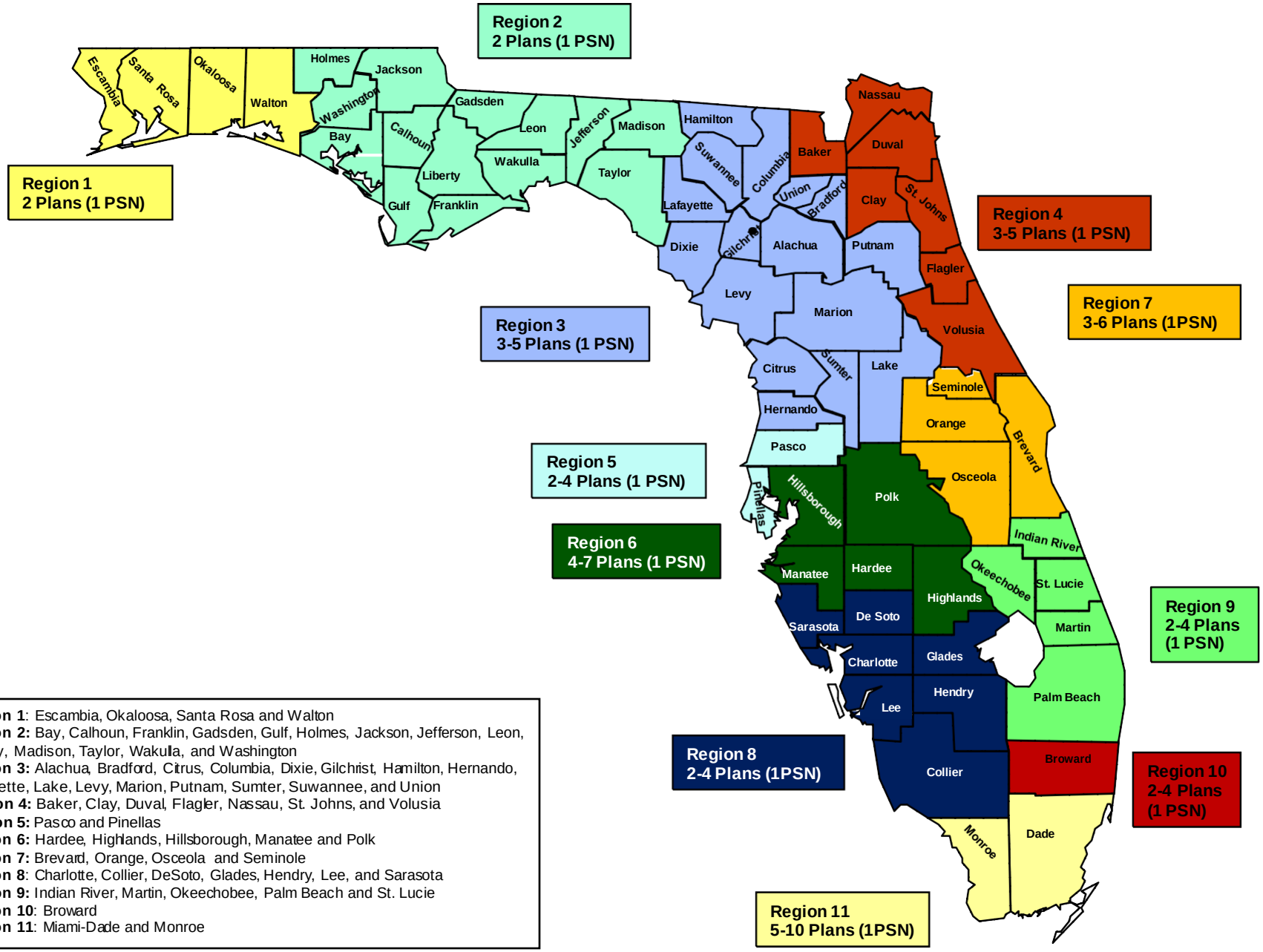

Region 1: Escambia, Okaloosa, Santa Rosa and Walton
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas
Region 6: Hardee, Highlands, Hillsborough, Manatee and Polk
Region 7: Brevard, Orange, Osceola and Seminole
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9: Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
Region 10: Broward
Region 11: Miami-Dade and Monroe

A managed care plan is defined as an eligible plan under contract with the Agency 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, or qualified pursuant to Florida Statutes, in the state 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 exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under state law or an accountable care organization authorized under federal law. For purposes of the statewide managed medical assistance program, the term also includes the Children's Medical Services Network authorized under state law.

In addition, the Agency 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 Agency may enter into contracts with a specialty plan whose target population includes no more than 10 percent of the enrollees of that region and is not subject to the regional plan number limits in order to better serve individuals.

As part of the ITN process, the Agency will establish preference criteria for reviewing ITN respondents as previously described. Such criteria will include, but not limited to, the Agency'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.

Excluded and Voluntary Populations - Statewide Managed Medical Assistance Program

Exempted Populations

Florida Medicaid recipients are required to become enrolled in the statewide managed medical assistance program for their primary and acute medical services unless exempt. Exempt recipients include:

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

Voluntary Populations

Additional provisions of the law establish that certain individuals who are exempt may voluntarily choose to participate in the statewide managed medical assistance program. Additional exempt recipients who may voluntarily enroll include:

- Medicaid recipients who have other creditable health care coverage, excluding Medicare.

- Medicaid recipients 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.
- Medicaid recipients who are residents of a developmental disabilities center.
- Medicaid recipients with developmental disabilities enrolled in the home and community based waiver pursuant to state law, and Medicaid recipients waiting for waiver services.

The new legislation provides that persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program.

Covered and Excluded Services - Statewide Managed Medical Assistance Program

The managed care plans will be required to cover, at a minimum, the following services:

(a) Advanced registered nurse practitioner.
(b) Ambulatory surgical treatment center.
(c) Birthing center.
(d) Chiropractic.
(e) Dental.
(f) Early periodic screening diagnosis and treatment services for recipients under age 21.
(g) Emergency.
(h) Family planning services and supplies. Pursuant to 42 C.F.R. s. 438.102, plans may elect to not provide these services due to an objection on moral or religious grounds, and must notify the Agency of that election when submitting a reply to an invitation to negotiate.
(i) Healthy Start services, except as provided in s. 409.975(4).
(j) Hearing.
(k) Home health agency.
(l) Hospice.
(m) Hospital inpatient.
(n) Hospital outpatient.
(o) Laboratory and imaging.
(p) Medical supplies, equipment, prostheses, and orthotics.
(q) Mental health.
(r) Nursing care.
(s) Optical services and supplies.
(t) Optometrist.
(u) Physical, occupational, respiratory, and speech therapy.
(v) Physician services, including physician assistant.
(w) Podiatric.
(x) Prescription drugs.
(y) Renal dialysis.
(z) Respiratory equipment and supplies.
(aa) Rural health clinic.
(bb) Substance abuse treatment.
(cc) Transportation to access covered services.

In addition, plans are authorized to customize their benefit packages to non-pregnant adults, vary cost sharing provisions, and provide coverage for additional services. The Agency is

required to evaluate the proposed benefit package to ensure that services are sufficient to meet the needs of the plans' enrollees and to verify actuarial equivalence.

Certain services are excluded from the plan benefit packages, and are "carved out" to remain under the fee-for-service system. Those services include services provided in a prescribed pediatric extended care facility, and the provision of anti-hemophilic factor replacement products to recipients diagnosed with hemophilia through the Agency's hemophilia disease management program.

Provider Network Requirements and Plan Accountability

Provider Network Requirements

In order to ensure access to necessary Medicaid services, the Agency is directed to establish specific standards for the number, type, and regional distribution of providers in plan networks. The Agency will ensure that plans maintain a network of providers in sufficient numbers to meet the needs of the recipients. 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 Agency 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.

Plans may limit the providers in their networks so long as network adequacy standards are meet 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.

In addition, the Agency will 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.

As previously noted, plans are required to negotiate in good faith with essential providers for one year and reimbursement for these essential providers is outlined.

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 an option, the exclusive use of mail-order pharmacies is not sufficient to meet network access standards. Furthermore, the Agency will evaluate the 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.

Plan Accountability and Performance Standards

The Agency will transition monitoring activities to provide enhanced plan accountability and clear performance standards. These requirements include, but are not limited to: posting of formulary or preferred drug list on a 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 Health Plan Employer Data and Information Set (HEDIS) measures with results published on each plan's 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 birth of a child to an enrollee.

Plans will be required to comply with the Agency's reporting requirements for the Medicaid Encounter Data System. In addition, the Agency will fine plans $5,000 per day for each day of noncompliance beginning on the 31st day. The Agency is required to notify the plan on the 31st day that the Agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance.

Additionally, program integrity requirements for plans will include but not be limited to:

- Plans must have an effective prepayment and postpayment review process including data analysis, system editing and auditing of network providers
- Plans must have in place procedures for reporting instances of fraud and abuse pursuant to Chapter 641.
- Plans must have administrative and management arrangements or procedures, including a mandatory compliance plan, designed to prevent fraud and abuse.

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 percent of revenue shall be retained by the plan.
2. Fifty percent of income above 5 percent and up to 10 percent shall be retained by the plan, and the other 50 percent refunded to the state.

3. One hundred percent of income above 10 percent 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 percent of revenue.

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 percent 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 managed care 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.

If a plan that is awarded an “additional contract” to ensure managed care 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.