RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 4, 2015

Ms. Heather Hostetler
Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Hostetler:

Enclosed for your review is a request to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-002064). The State is seeking federal authority to assign Medicaid-eligible individuals who are mandated to participate in Florida's MMA program, a component of the Statewide Medicaid Managed Care program, to a managed care plan immediately after eligibility determination. The State is requesting an effective date of September 1, 2015.

In compliance with 42 CFR 431.408 and STCs #7 and #15 of the MMA Waiver including: the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the SSA as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, the Agency for Health Care Administration (Agency) held a 30-day public notice and public comment period that began March 27, 2015 and ended April 26, 2015, for the MMA Waiver Amendment.

A summary of the proposed amendment, public notice document and comment period was made available on the Agency's website at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-03.shtml

We appreciate your consideration of this request and your efforts in working with our staff on amending Florida's 1115 MMA Waiver. Should you have any questions, please contact Heather Morrison of my staff at (850) 412-4034. We look forward to continuing to work with you.

Sincerely,

[redacted]

Justin M. Senior
Deputy Secretary for Medicaid

JMS/hm
Enclosures
cc: Jackie L. Glaze, CMS-RO

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# Florida Managed Medical Assistance Program
# 1115 Research and Demonstration Waiver
(Project Number 11-W-002064)

# Waiver Amendment Request
# May 4, 2015

**Posted on Agency Website**
http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-03.shtml

**Florida Agency for Health Care Administration**

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# I. Purpose, Goals and Objectives

## A. Statement of Purpose

The State is seeking federal authority to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-002064) to assign Medicaid-eligible individuals who are mandated to participate in Florida's MMA program, a component of the Statewide Medicaid Managed Care program, to a managed care plan immediately after eligibility determination. The State is requesting an effective date of September 1, 2015.

The proposed amendment will allow individuals to be enrolled in a managed care plan immediately after eligibility determination. Under the proposed amendment, individuals will receive both their managed care plan assignment and information about the managed care plan choices in their area, to encourage an active selection, immediately after eligibility determination. Appendix D includes a copy of the letter that will be sent to recipients upon Medicaid eligibility determination.

During the initial 30-day period post-enrollment, if a recipient decides to change plans, the change will take effect the first day of the following month. The 30-day change period will be followed by a 90-day disenrollment period. During the 90-day disenrollment period, if a recipient decides to change plans, the change will take effect the first day of the following month.

The State is not requesting any changes to the MMA waiver authorities or expenditure authorities authorized July 31, 2014. The State is requesting to amend Special Term and Conditions (STC) #2, #21, #22, and #40 of this waiver to remove the 30-day period between eligibility determination and managed care plan enrollment and to amend the auto-assignment criteria to conform to Section (s.) 409.977(2), Florida Statutes, which states:

> When automatically enrolling recipients in managed care plans, the agency shall automatically enroll based on the following criteria: (a) Whether the plan has sufficient network capacity to meet the needs of the recipients. (b) Whether the recipient has previously received services from one of the plan's primary care providers. (c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans."

The STCs of the MMA waiver can be found at the link provided on page 2 of this document.

Summary Description of the Populations

New enrollees who are mandated to participate in the MMA program include Supplemental Security Income (SSI) individuals, children and families, including pregnant women, and aged, blind, and disabled persons, including those needing institutional care. These mandatory participants are required to enroll in a managed care plan as a condition of receipt of Medicaid benefits. A complete description of mandatory managed care participants can be found on pages 8 and 9 of this document.

The proposed amendment will allow new enrollees who are mandated to participate in the MMA program to immediately take advantage of the robust provider network and access standards required of the plans while allowing these individuals to immediately access the enhanced care coordination and expanded benefits offered by the plans without the 30-day delay period.

## B. Goals and Objectives

**1. Waiver Goals and Objectives**: The goals of the MMA program are to improve outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The State envisions a Medicaid program where all recipients will choose their managed care plan from a list of nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The State provides oversight focused on improving access and increasing quality of care. The overall program objectives are:

- Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.

- Improving 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).

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

These goals and objectives will empower participants, provide for the accountability of providers, and facilitate program management and fiscal integrity for government. The fundamental elements of the program along with the consumer protections can be found in Section I of the MMA waiver extension. This document can be found on the Agency for Health Care Administrations (Agency's) website at the following link:

http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth.shtml

**2. Amendment Summary and Objective**:

This amendment is requested to assign Medicaid-eligible individuals who are mandated to participate in the MMA program in a managed care plan immediately after eligibility determination. In addition to the objectives noted earlier for all MMA program enrollees, the objectives of the amendment are to assign new enrollees to immediately take advantage of the following:

- expanded benefits offered by the plans,
- robust provider networks available to plan enrollees,
- higher service level agreements with which plans are required to comply, and
- care coordination resources and services available to plan enrollees.

## C. Current Program

**1. Managed Care:** The State currently operates Florida's Medicaid managed care program under the 1115 MMA Waiver. For a comprehensive description of the MMA program, please see Section III of this document.

1115 MMA Waiver:

On June 14, 2013, the Centers for Medicare and Medicaid Services (Federal CMS) approved an amendment to the demonstration, which retains all of the improvements noted above, but allowed the State to extend an improved model of managed care to all counties in Florida subject to approval of an implementation plan and a determination of readiness based on the elements of the approved plan. The amendment also changed the name of the demonstration to the Florida MMA program.

**2. Low Income Pool (LIP)**: The LIP program provides government support for the safety net providers that furnish uncompensated care to the Medicaid, underinsured and uninsured populations. It consists of a capped annual allotment of $2.167 billion total computable for 2014-2015. The LIP program is designed to establish new, or enhance existing, innovative programs that meaningfully enhance the quality of care and the health of low income populations. Programs include the quality-based LIP programs tracked through metric outcomes to ensure the access to quality care.[1]

## D. Federal and State Waiver Authority

The following is a historical description of the federal and state authority granted since authorization of the waiver (Project Number 11-W-00206/4) was obtained in 2005.

**1. Initial 5-Year Period (2006-2011):** On October 19, 2005, Florida's 1115 Research and Demonstration Waiver named "Medicaid Reform" was approved by Federal CMS. The program was implemented in Broward and Duval Counties July 1, 2006 and expanded to Baker, Clay and Nassau Counties July 1, 2007. The program was terminated August 1, 2014 with the implementation of the MMA program. The state authority to operate this program is located in s. 409.91211, F.S., and sunset October 1, 2014.

**2. Three-Year Extension Period (2011-2014):** On December 15, 2011, the State received Federal CMS approval to extend the waiver to maintain and continue operations of Medicaid Reform for the period July 1, 2011 to June 30, 2014.

**3. MMA Waiver Amendment (2014):** On June 14, 2013, the State received Federal CMS approval to amend the waiver to terminate the Medicaid Reform program and implement the MMA program as approved by Federal CMS. The name of the waiver was changed to Florida's 1115 Managed Medical Assistance Waiver. The STCs can be viewed on the Agency's website at the following link:

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/SpecialTermsandConditionsCMSApprovedJuly312014.pdf

[1] Currently authorized until June 30, 2015.

**4. Three-Year Waiver Extension (2014-2017):** On November 27, 2013, the Agency submitted an extension request to extend authority for the 1115 MMA Waiver an additional 3-years (July 31, 2014 - June 30, 2017). The Agency received approval of the 3-year extension from Federal CMS on July 31, 2014. The effective dates of the waiver renewal period are July 31, 2014 through June 30, 3027

## E. Waiver Amendment Requirements

The State will submit the MMA Waiver amendment to Federal CMS in accordance with STCs #7 and #15 of the MMA waiver and 42 Code of Federal Regulations (CFR) 431.408. The following is a description of the required public notice document.

Public Notice Document: The State is posting this "Public Notice" document to solicit public input 30 days prior to submission of the amendment request to Federal CMS. This public notice document is required to include a comprehensive description of the amendment application that contains sufficient detail to ensure meaningful input from the public, including:

(A) The program description, goals, and objectives of the amendment to be implemented under the demonstration project, including a description of the current or new beneficiaries who will be impacted by the demonstration. (See Section I of this document.)

(B) To the extent applicable, the proposed health care delivery system and the eligibility requirements, benefit coverage and cost sharing (premiums, co-payments, and deductibles) required of individuals that will be impacted by the demonstration, and how such provisions vary from the State's current program features. (See Section II of this document.)

(C) An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request. (See Section IV of this document.)

(D) The hypothesis and evaluation parameters of the demonstration. (See Section VI of this document.)

(E) The specific MMA Waiver and expenditure authorities that the State believes to be necessary to authorize the demonstration. (See Section VII of this document.)

# II. Public Process

This section of the document provides a summary of public notice and input process used by the State in compliance with 42 CFR 431.408 and STCs #7 and #15 of the MMA Waiver including: the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to s. 1902(a)(73) of the Social Security Act (SSA) as amended by s. 5006(e) of the American Recovery and Reinvestment Act of 2009.

## A. Consultation with Indian Health Programs

The Agency consulted with the Indian Health Programs[2] located in Florida through written correspondence, to solicit input on the amendment request. Appendix A of this document provides the correspondence sent on March 25, 2015, to the Seminole Tribe and Miccosukee Tribe requesting input on the amendment request.

## B. Public Notice Process

The following list describes the notification process used to inform stakeholders of the public meetings to be held to solicit input on the amendment request.

- Publish public notices for the two public meetings in the Florida Administrative Register (FAR) in compliance with Chapter 120, Florida Statutes (F.S.).
- Email the meeting information to individuals and organizations from the interested parties list that was created during the development of the initial waiver application and has been updated regularly thereafter.
- Release Agency Media Alerts announcing the meetings.
- Post on the Agency's home webpage a prominent link to the webpage where the following information can be found: the public meeting schedule including dates, times and locations as well as this public notice document for the amendment request. The meeting materials and the public notice document can be viewed by clicking on the following link:

  http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth_amend_waiver_2015-03.shtml

## C. Florida Medicaid Advisory Meetings

The Agency asked for input on this amendment request from the members of the Medicaid Medical Care Advisory Committee (MCAC) and the public at large. The public meeting notices were published in FAR. During the meetings, the Agency provided a description of the amendment request and obtained input on the amendment request. The agenda and presentation materials are posted on the Agency's website provided above.

- Public meeting held in Tampa on April 7, 2015.
- MCAC meeting held in Tallahassee on April 14, 2015.

[2] The State of Florida has two federally recognized tribes: Seminole Tribe and Miccosukee Tribe; and does not have any Urban Indian Organizations.

Florida Medicaid's Medical Care Advisory Committee

The MCAC is mandated in accordance with s. 431.12, Title 42, CFR, based on s. 1902(a)(4) of the SSA. The purpose of the MCAC is to provide input on a variety of Medicaid program issues, and to make recommendations to the Agency on Medicaid policies, rules and procedures.

The MCAC is comprised of: board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income people; members of consumer groups, including four representatives of Medicaid recipients; and representatives of state agencies involved with the Medicaid program, including the secretaries of the Florida Department of Children and Families, the Florida Department of Health and the Florida Department of Elder Affairs, or their designees.

## D. Public Meetings

The State published a public meeting notice in FAR on March 27, 2015, inviting all interested parties to the two public meetings listed in the table below, which provides the dates, times and locations. Individuals who were unable to attend the meeting in person were able to participate via conference call by using the toll-free number provided in the public notice documents. During the meetings, the Agency provided an overview of the MMA Waiver and description of the amendment request and allowed time for public comments. Table 1 provides the schedule of public meetings held regarding the proposed amendment.

**Table 1**
**Schedule of Public Meetings**

| Location | Date | Time |
|---|---|---|
| **Tampa**<br>Agency for Health Care Administration, 6800 North Dale Mabry Highway,<br>Main Training Room,<br>Tampa, FL 33614<br><br>Conference Line: 1 877 299.4502<br>Participant Code: 769 730 07# | April 7, 2015 | 1:00 p.m. – 3:30 p.m. |
| **Tallahassee**<br><br>Agency for Health Care Administration<br>2727 Mahan Drive<br>Building 3<br>Conference Room A<br>Tallahassee, FL 32308<br><br>Conference Line: 1 877 299.4502<br>Participant Code: 758 844 10# | April 14, 2015 | 3:00 p.m. – 5:00 p.m. |

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting was asked to advise the agency at least 7 days before the workshop/meeting by contacting Heather Morrison at (850) 412-4034 or by email at Heather.Morrison@ahca.myflorida.com. If you are hearing or speech impaired,

please contact the agency using the Florida Relay Service, 1 (800) 955-8771 (TTY) or 1 (800) 955-8770 (Voice).

## E. Public Notice Document Made Available to the Public

The Agency posted on its website (link provided on page 5), beginning March 27, 2015 through April 26, 2015, the public notice document, the approved MMA Waiver documents (STCs of the waiver and the waiver and expenditure authorities document), and the Florida law (Part IV of Chapter 409, F.S.) that established the MMA program.

## F. Submission of Written Comments

The Agency's website provided the public the option of submitting written comments on the amendment request by mail or email (address located below). In addition, the Agency asked attendees of the public meetings to submit written comments.

**Mail comments and suggestions to:**

1115 MMA Amendment Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

**The public may also e-mail comments and suggestions to:**

FLMedicaidWaivers@ahca.myflorida.com

## H. Summary of Public Comments

The following summarizes the public comments received during the 30-day comment period for the waiver amendment request that began March 27, 2015 and ended April 26, 2015.

**Summary of Comments -** The comments received are grouped by topic.

General Comments

Comments were received in favor of the amendment to remove the waiting period from when recipients become eligible and when they are enrolled in a health plan and to amend the auto-assignment criteria. Support was expressed to eliminate the time between Medicaid enrollment and enrollment in a health plan as it would help numerous amounts of patients avoid hospital admittance by getting access to services in a health plan right away. Comments were received to support the proposed changes as it will result in improved continuity of care and reduce the average length of hospital stays for patients waiting to be placed in nursing homes.

30-Day Post Enrollment Period

Comments were received to clarify the 30-day post-enrollment period in relation to the frequency and timing for recipient enrollment and health plan assignment. Concerns were expressed over the frequency with which a recipient can change plans within the time period. Other areas that generated comments pertaining to this time period were having an individual

pick the plan they want at the time they are deemed eligible and having the 30-day change period waived and the individual moves straight to the 90-day disenrollment period; and timing between health plans covering services retroactively in certain instances, e.g., hospice, where application for Medicaid was submitted, the patient was admitted into hospice, but Medicaid eligibility was determined a month later. Comment was received in favor of the amendment to remove the waiting period from when recipients become eligible and when they are enrolled in a health plan and to amend the auto-assignment criteria.

90-Day Disenrollment Period

Concerns were expressed regarding the frequency and timing when the recipient changes plans during this period.

Auto-Assignment/Recipient Choice

Comments were received pertaining to recipients being able to choose their health plans; the criteria or algorithm being considered when health plans are assigned to recipients who do not choose a plan; the criteria used if the recipient is new to Medicaid; the criteria used for plan choice in comprehensive plans; mandatory recipients being informed of the plans available in their area; having the Agency work with doctors to help auto-assign recipients. Concern was also expressed regarding Florida Statutes if the recipients are auto-assigned and amending STC #22. Support was given that recipients should be able to pick their plan and their doctors.

Impact on Providers

Concerns were expressed regarding the logistical and financial challenges for providers and that the Agency needs to let the providers know how this is going to work.

Specialty Plans

Comments were received pertaining to specialty plans being affected by this amendment and whether they can be excluded; foster care and the timeframe involved in getting into a health plan; specialty plans taking precedence when auto-assigning a plan.

Rates/Claims/Payments

Comments were received about fee-for-service and capitation rates and claims and that transparency in the rate development process is key factor; challenges faced by the plans to pay the providers; capitation and the 30-day post-enrollment period; and partial month payments.

Authorizations

Comments were received on the effects of this amendment on service authorizations (prior and post) and retroactivity.

Presumptive Eligibles

Concerns were expressed regarding confirmation that presumptive eligibles are excluded; but that if they are included, then a separate rate cell will need to be developed due to the nature of their current condition—higher risk.

Continuity of Care

Concerns were expressed regarding the requirements for coordination of care and continuity of care during the 30-day post-enrollment period; continuity of care related to recipients choosing a different health plan as often as they can throughout the cycle.

Communication/Outreach

Comments were received pertaining to health plan information distributed to eligible individuals during the 30-day post-enrollment period and will plans be able to do outreach during that time.

DCF/Choice Counseling

Concerns were expressed regarding health plan selection assistance offered to the recipient; what roles would DCF and Choice Counseling play and would it be a collaborative effort.

Eligibility File

Comments were received regarding disenrollment within the change period and the eligibility file.

Pregnant Woman and Infants

Concerns were expressed regarding the client's health plan status as of the first month of eligibility; pregnant women being able to keep their prenatal care physician; and continuity of care.

Hospices

Comments were received pertaining to the effects of this amendment on hospice beneficiaries and community hospice and nursing home hospice cases and the timing of the 30- and 90-day periods.

Miscellaneous Comments

The following comments were made but do not pertain to the amendment presented. Comments were received regarding lack of licensure in Florida for art therapists; problems with current MMA enrollees reapplying for Medicaid and being assigned to a different provider; primary care physicians and specialists for recipients are not always in the same plan; the lack of TBI/SCI specialists in the plans, which then involves transportation, which can further cause damage to the recipient; for DME services, Univita should be held accountable as a subcontractor to plan and the plan as well for these contracted services; infants being put on straight Medicaid and then later on being enrolled in a health plan without knowledge of that happening; mothers should be able to select the plan the newborn is enrolled in; the newborn should not automatically be enrolled in the mother’s plan; there is a delay in enrollment for newborns being enrolled in the mother’s plan; newborn claims are denying as the newborn is not showing up in the plan.

# III. Current Program Overview

The following provides a description of the current MMA program, an integrated health care delivery system, by which eligible recipients will receive their primary and acute medical care services as specified in Florida law and as approved by Federal CMS. The proposed amendment will assign Medicaid-eligible individuals who are mandated to participate in the MMA program to a managed care plan immediately after eligibility determination.

## A. Eligibility

**1. Eligibility for Medicaid**: The Florida Department of Children and Families 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 MMA 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.

**2. Eligibility for the MMA Program**: MMA program participants are individuals eligible under the approved state plan, who reside in the MMA program regions and who are described below as "mandatory participants" or as "voluntary participants". Mandatory participants are required to enroll in a managed care plan or as a condition of receipt of Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a managed care plan to receive Medicaid benefits.

a. Mandatory Managed Care Participants – Individuals who belong to the categories of Medicaid eligibles listed in the following table, and who are not listed as excluded from mandatory participation are required to be MMA program participants. Table 2 provides a listing of the mandatory managed care participants.

**Table 2**
**Mandatory Managed Care Participants**

| Mandatory State Plan Eligibility Groups | Population Description | Funding Stream | CMS-64 Eligibility |
|---|---|---|---|
| Infants under age 1<br>Population 2 | No more than 206% of the Federal Poverty Level (FPL). | Title XIX | TANF & related grp |
| Children 1-5<br>Population 2 | No more than 140% of the FPL. | Title XIX | TANF & related grp |
| Children 6-18<br>Population 2 | No more than 133% of the FPL. | Title XIX | TANF & related grp |
| Blind/Disabled Children<br>Population 1 | Children eligible under SSI, or deemed to be receiving SSI. | Title XIX | Aged/Disabled |

| Table 2<br>Mandatory Managed Care Participants | | | |
|---|---|---|---|
| **Mandatory State Plan Eligibility Groups** | **Population Description** | **Funding Stream** | **CMS-64 Eligibility** |
| IV-E Foster Care and Adoption Subsidy Population 2 | Children for whom IV-E foster care maintenance payments s or adoption subsidy payments are received – no Medicaid income limit. | Title XIX | TANF & related grp |
| Pregnant women Population 2 | Income not exceeding 191% of FPL. | Title XIX | TANF & related grp |
| Section 1931parents or other caretaker relatives Population 2 | No more than AFDC Income Level (Families whose income is no more than about 31% of the FPL or $486 per month for a family of 3.) | Title XIX | TANF & related grp |
| Aged/Disabled Adults Population 1 | Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by SSA. | Title XIX | Aged/Disabled |
| Former foster care children up to age 26 | Individuals who are under age 26 and who were in foster care and receiving Medicaid when they aged out. | Title XIX | TANF & related grp |
| **Optional State Plan Groups** | | | |
| State-funded Foster Care or Adoption assistance under age 18 | Who receive a state Foster Care or adoption subsidy, not under title IV-E. | Title XIX | TANF & related grp |
| Individuals eligible under a hospice-related eligibility group | Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple. | Title XIX | Aged/Disabled |
| Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236 Population 1 | This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category in paragraph (c). | Title XIX | Aged/Disabled |
| Institutionalized individuals eligible under the special home and community based waiver group specified at 42 CFR 435.217 Population 1 | This group includes institutionalized individuals eligible under this special HCBS waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category in paragraph (c). | Title XIX | Aged/Disabled |

b. Medicare-Medicaid Eligible Participants - Individuals fully eligible for both Medicare and Medicaid are required to participate in the MMA program for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program

will not impact individuals' Medicare benefits. Medicare-Medicaid beneficiaries will be afforded the opportunity to choose an MMA plan. However, to facilitate enrollment, if the individual does not elect an MMA plan, then the individual will be assigned to an MMA plan by the state using the criteria outlined in STC #22.

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

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

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

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

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

v. Children receiving services in a prescribed pediatric extended care (PPEC) facility. Upon federal approval of the 2014 waiver extension, the state will work with CMS to permit this population to voluntarily enroll in the MMA program in accordance with state law that became effective on June 4, 2014. This change will be effective prospectively, following CMS approval of an applicable demonstration amendment.

vi. Residents of group home facilities licensed under s. 393.067, F.S., receiving residential services in family living environments including supervision and care necessary to meet their physical, emotional, and social needs[3]

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

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

ii. Family planning waiver eligibles; and

iii. Individuals eligible as women with breast or cervical cancer.

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

[3] Pending approval from Federal CMS.

## B. Current Enrollment and Disenrollment

The following describes the current enrollment and disenrollment process in accordance with STCs #21 through #25 of the MMA Waiver. The STCs can be found at the link provided on page 3 of this document.

**1. New Enrollees**: At the time of eligibility determination, individuals who are mandated to participate in the MMA program will receive information about plan choices in their region. New enrollees will be informed of their options in selecting an authorized plan and will be provided the opportunity to talk with a choice counselor to obtain additional information in making a choice. New enrollees will be required to select a plan within 30 days of eligibility determination. If the individual does not select a plan within the 30-day period, the Agency may assign the individual into a managed care plan in the MMA program. Once an individual has made their choice, they will be able to contact the Agency or the Agency's designated choice counselor to register their plan selection. Once the plan selection is registered and takes effect, the plan will communicate to the enrollee, in accordance with 42 CFR 438.10, the benefits covered under the plan, including dental benefits, and how to access those benefits.

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

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

b) The plan has previously enrolled the enrollee as a member, or one of the plan's primary care providers (PCPs) has previously provided health care to the enrollee;

c) The State has knowledge that the enrollee has previously expressed a preference for a particular plan as indicated by Medicaid fee-for-service (FFS) claims data, but has failed to make a choice; and,

d) The plan's PCPs are geographically accessible to the recipient's residence.

**3. Auto Enrollment for Special Populations**: For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI recipient to a plan, the Agency will determine whether the SSI recipient has an ongoing relationship with a provider or plan; and if so, the Agency will assign the SSI recipient to that plan whenever feasible. Those SSI recipients who do not have such a provider relationship must be assigned to a plan using the assignment criteria previously outlined. In addition, the Agency will use the following parameters when assigning a recipient to a plan.

a) To promote alignment between Medicaid and Medicare, each recipient who is enrolled with a Medicare Advantage Organization, will first be assigned to any plan in the recipient's region that is operated by the same parent organization as the recipient's Medicare Advantage Organization. If there is no match of parent organization or appropriate plan within the organization, then the recipient will be assigned as in auto-enrollment as listed in paragraphs 2(a) -2(d) above.

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

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

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

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

**4. Lock-In/Disenrollment**: Once a mandatory enrollee has selected or been assigned a plan, the enrollee will be enrolled in the plan for a total of 12 months, which includes a 90-day disenrollment period. Once an individual is enrolled into a plan the individual has 90 days to voluntarily disenroll from that plan without cause and select another plan. If an individual chooses to remain in the plan past 90 days the individual will remain in the selected plan for an additional nine months for a total enrollment period of 12 months, and no further changes may be made until the next open enrollment period, except for cause. Cause shall include: enrollee moves out of the plan's service area; enrollee needs related services to be performed at the same time, but not all related services are available within the network; and the enrollee's treating provider determines that receiving the services separately would subject the enrollee to unnecessary risk. Other reasons for cause may include but are not limited to: quality of care, lack of access to necessary services, an unreasonable delay or denial of services, inordinate or inappropriate changes of PCPs, service access impairments due to significant changes in the geographic location of services, or fraudulent enrollment. Enrollees may transfer between PCPs within the same plan. Voluntary enrollees may disenroll from the plan at any time.

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

**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 demonstration enrollees in the same managed care plan they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended.

## C. Information and Choice

**1. Enrollee Choice**: The State assures Federal 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 MMA regions. The State will operate the choice counseling program in accordance with STCs #54-58 of the waiver.

**2. Enrollee Information**: The Agency's designated contractor will ensure that enrollees are provided with full and complete information about their plan options. The Agency's designated contractor will provide information regarding an individual's choice to select a plan.

Through the designated contractor, the Agency offers an extensive enrollee education and rating system so individuals will fully understand their choices and be able to make an informed

selection. Outcomes important to enrollees will be measured consistently for each plan, and the data will be made available publicly.

Enrollment materials have been provided in a variety of ways including the internet, print, telephone, and face-to-face. All written materials are written at the fourth-grade reading level and available in a language other than English when five percent of the county speaks a language other than English. The Agency will ensure to provide oral interpretation services, regardless of the language, and other services for impaired recipients, such as TTD/TTY, without charge to the enrollee as needed. 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 Federal CMS that it will provide information in accordance with Section 1932(a)(5) of the SSA and 42 CFR 438.10, Information Requirements.

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

## D. Benefits

**1. Customized Benefit Packages**: Currently, none of the MMA plans have chosen to offer Customized Benefits Packages and chose to provide all State Plan services as well as Expanded Benefits. Customized benefits are described in STCs #26 -#31 of the waiver. The STCs of the MMA Waiver can be found at the link provided on page 3 of this document.

**2. Expanded Benefits under MMA program:** Expanded benefits are those services or benefits not otherwise covered in the MMA program's list of required services, or that exceed limits outlined in the Medicaid State Plan and the Florida Medicaid Coverage and Limitations Handbooks and the Florida Medicaid Fee Schedules. The plans may offer expanded benefits in addition to the required services listed in the MMA Exhibit for MMA plans and Comprehensive LTC plans, and the LTC Exhibit for Comprehensive LTC plans and LTC plans, upon approval by the State. The plans may request changes to expanded benefits on a contract year basis, and any changes must be approved in writing by the State. Table 3 provides a list of the expanded benefits approved by the Agency that are being offered by the MMA standard plans in 2015. Table 4 provides a list of the expanded benefits approved by the Agency that are being offered by the MMA specialty plans in 2015.

**Table 3**
**Expanded Benefits Offered by Standard Plans**

| List of Expanded Benefits | Amerigroup | Better Health | Coventry | Humana | Integral | Molina | Preferred | Prestige | SFCCN | Simply | Staywell | Sunshine | United |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult dental services (Expanded) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Adult hearing services (Expanded) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Adult vision services (Expanded) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Art therapy | Y | | | Y | | Y | | | | | Y | Y | |

| Table 3<br>Expanded Benefits Offered by Standard Plans | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **List of Expanded Benefits** | **Amerigroup** | **Better Health** | **Coventry** | **Humana** | **Integral** | **Molina** | **Preferred** | **Prestige** | **SFCCN** | **Simply** | **Staywell** | **Sunshine** | **United** |
| **Equine therapy** | | | | | | | | | | | Y | | |
| **Home health care for non-pregnant adults (Expanded)** | Y | Y | Y | Y | Y | Y | | Y | Y | Y | Y | Y | Y |
| **Influenza vaccine** | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| **Medically related lodging & food** | | Y | | Y | Y | Y | | Y | | Y | Y | Y | |
| **Newborn circumcisions** | Y | Y | Y | Y | Y | Y | | Y | Y | Y | Y | Y | Y |
| **Nutritional counseling** | Y | Y | Y | Y | Y | | Y | Y | | Y | Y | Y | |
| **Outpatient hospital services (Expanded)** | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| **Over the counter medication and supplies** | Y | Y | Y | Y | Y | Y | Y | Y | | Y | Y | Y | Y |
| **Pet therapy** | | | | Y | | Y | | | | | Y | | |
| **Physician home visits** | Y | Y | Y | Y | Y | Y | | Y | | Y | Y | Y | Y |
| **Pneumonia vaccine** | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| **Post-discharge meals** | Y | Y | Y | Y | Y | Y | Y | | | Y | Y | Y | Y |
| **Prenatal/Perinatal visits (Expanded)** | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| **Primary care visits for non-pregnant adults (Expanded)** | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| **Shingles vaccine** | Y | Y | Y | Y | Y | Y | | Y | Y | Y | Y | Y | Y |
| **Waived co-payments** | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |

| Table 4<br>Expanded Benefits Offered by Specialty Plans | | | | | | |
|---|---|---|---|---|---|---|
| **List of Expanded Benefits** | **CMSN Plan** | **Magellan (Serious Mental Illness)** | **Freedom (Chronic/Duals)** | **Sunshine (Child Welfare)** | **Clear Health Alliance (HIV/AIDS)** | **Positive Health (HIV / AIDS)** |
| | | | | | | |
| **Adult dental services (Expanded)** | | Y | | Y | Y | Y |
| **Adult hearing services (Expanded)** | | | | Y | Y | Y |
| **Adult vision services (Expanded)** | | Y | | Y | Y | Y |
| **Art therapy** | | | | Y | | |
| **Equine therapy** | | | | | | Y |
| **Home and Community-Based Services** | | Y | | | Y | |
| **Home health care for non-pregnant adults (Expanded)** | | Y | | Y | Y | |
| **Influenza vaccine** | | Y | | Y | Y | Y |
| **Intensive Outpatient Therapy** | | Y | | | Y | |
| **Medically related lodging & food** | | Y | | Y | Y | Y |
| **Newborn circumcisions** | | Y | | Y | Y | Y |
| **Nutritional counseling** | | Y | | Y | Y | |

| Table 4<br>Expanded Benefits Offered by Specialty Plans | | | | | | |
|---|---|---|---|---|---|---|
| **List of Expanded Benefits** | **CMSN Plan** | **Magellan (Serious Mental Illness)** | **Freedom (Chronic/Duals)** | **Sunshine (Child Welfare)** | **Clear Health Alliance (HIV/AIDS)** | **Positive Health (HIV / AIDS)** |
| **Outpatient hospital services (Expanded)** | | Y | | Y | Y | Y |
| **Over the counter medication and supplies** | | Y | | Y | Y | Y |
| **Pet therapy** | | | | | | |
| **Physician home visits** | | | | Y | Y | |
| **Pneumonia vaccine** | | Y | | Y | Y | Y |
| **Post-discharge meals** | | Y | | Y | Y | |
| **Prenatal/Perinatal visits (Expanded)** | | Y | | Y | Y | Y |
| **Primary care visits for non-pregnant adults (Expanded)** | | Y | | Y | Y | Y |
| **Shingles vaccine** | | Y | | Y | Y | Y |
| **Waived co-payments** | | Y | | Y | Y | Y |
| **NOTE: Details regarding scope of covered benefit may vary by managed care plan.** | | | | | | |

**3. Benefit Packages:** In addition to the expanded benefits available under the MMA program that are listed in Table 3 and Table 4 of this document, the MMA plans will provide standard benefits in accordance with the Florida Medicaid State Plan, the Florida Medicaid coverage and limitations handbooks, and the Florida Medicaid fee schedules. Table 5 provides the standard benefits that will be provided under the MMA contracts that were executed by the MMA plans.

| Table 5<br>MMA Plan Services | |
|---|---|
| **(1)** | **Advanced Registered Nurse Practitioner** |
| **(2)** | **Ambulatory Surgical Center Services** |
| **(3)** | **Assistive Care Services** |
| **(4)** | **Behavioral Health Services** |
| **(5)** | **Birth Center and Licensed Midwife Services** |
| **(6)** | **Clinic Services** |
| **(7)** | **Chiropractic Services** |
| **(8)** | **Dental Services** |
| **(9)** | **Child Health Check Up** |
| **(10)** | **Immunizations** |
| **(11)** | **Emergency Services** |
| **(12)** | **Emergency Behavioral Health Services** |
| **(13)** | **Family Planning Services and Supplies** |
| **(14)** | **Healthy Start Services** |
| **(15)** | **Hearing Services** |
| **(16)** | **Home Health Services and Nursing Care** |
| **(17)** | **Hospice Services** |
| **(18)** | **Hospital Services** |
| **(19)** | **Laboratory and Imaging Services** |
| **(20)** | **Medical Supplies, Equipment, Protheses and Orthoses** |
| **(21)** | **Optometric and Vision Services** |

| Table 5<br>MMA Plan Services | |
|---|---|
| **(22)** | **Physician Assistant Services** |
| **(23)** | **Podiatric Services** |
| **(24)** | **Practitioner Services** |
| **(25)** | **Prescribed Drug Services** |
| **(26)** | **Renal Dialysis Services** |
| **(27)** | **Therapy Services** |
| **(28)** | **Transportation Services** |

## E. Cost Sharing

**Premiums and Co-Payments**. The State will pre-approve all cost sharing allowed by the plans. Cost-sharing must be consistent with the state plan except that the plans may elect to assess cost sharing that is less than what is allowed under the state plan in accordance with STC #32 of the MMA Waiver. Table 6 provides the current cost sharing, including co-payments and co-insurances.

| Table 6<br>Cost Sharing | |
|---|---|
| **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 |
| Federally Qualified Health Centers | $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 are responsible for cost-sharing for services. The Agency reviewed and approved cost-sharing requirements as part of the benefit packages. Consistent with 42 CFR 447.53(b), cost-sharing is not required for children through age 18, pregnant women, institutionalized individuals, emergency service or for family planning services and supplies, unless otherwise authorized by Federal CMS. The Agency encouraged plans

during the negotiation process 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. 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. All MMA plans have waived co-payments as an expanded benefit.

**2. Healthy Behaviors**: The Agency has required the managed care plans to establish Healthy Behaviors programs to encourage and reward healthy behaviors. For Medicare and Medicaid recipients who are enrolled in both an MMA plan and a Medicare Advantage plan, the MMA plan must coordinate their Healthy Behaviors programs with the Medicare Advantage plan to ensure proper coordination. In the Agency monitors to ensure that each plan has, at a minimum, a medically approved smoking cessation program, a medically directed weight loss program, and an alcohol or substance abuse treatment program that meet all state requirements.

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

**3. Additional Programs:** The Healthy Start Program, the Program for All Inclusive Care for Children and the Comprehensive Hemophilia Program are new programs added to this demonstration. They were previously authorized under Florida's Section 1915(b) Medicaid Managed Care Waiver.

## F. Health Care Delivery System

**1. MMA Program**: The MMA program operates statewide and is guided by principles designed to improve coordination and patient care while fostering fiscal responsibility. Mandatory recipients are required to participate in the MMA program to receive their health care services.

The program ensures individual choice, increased access, improved quality, efficiency and fiscal integrity while stabilizing cost. The program is an integrated model that manages all care. For the first year of operation of the MMA program, the plans will be required to use the state's preferred drug list.

**2. Regions**: Florida law established 11 regions within the State of Florida for the MMA program, and outlines the number of plans authorized to provide services in each region. Table 7 provides a list of the counties by the 11 regions.

**Table 7**
**Regions for the MMA Program**

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

| Table 7<br>Regions for the MMA Program | |
|---|---|
| **Region** | **Counties** |
| **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 |

**3. MMA Plans:** Table 8 provides a listing of contracted MMA plans.

| Table 8<br>MMA Plans | |
|---|---|
| **Plan Type** | **Plan Name** |
| **Standard Plans** | **Better Health**<br>**Integral Quality Care**<br>**Preferred**<br>**Prestige Health Choice**<br>**Simply**<br>**Staywell**<br>**South Florida Community Care Network** |
| **Specialty Plans**<br>Plans contracted to provide services to a targeted population | **Clear Health Alliance**<br>**Freedom Health**<br>**Magellan Complete Care**<br>**Positive Health Care**<br>**Children's Medical Services Network** |
| **Comprehensive Plan**<br>Plans also contracted to provide LTC services under the 1915(b)(c) Long-term Care Waiver. | **Amerigroup Florida**<br>**Coventry**<br>**Humana Medical Plan**<br>**Molina**<br>**United Healthcare** |
| **Comprehensive & Specialty Plan**<br>This MMA plan is also contracted as a specialty plan providing services to a targeted population and LTC services under the 1915(b)(c) Long-term Care Waiver. | **Sunshine Health** |

**4. Number of Plans per Region**: Florida law specified a minimum and maximum number of plans, along with the requirement that, of the total contracts awarded per region, at least one plan shall be a provider service network (PSN) if any PSNs submit a responsive bid. As noted in Table 9, there is a minimum of two plan choices in each of the 11 regions.

**Table 9**
**MMA Plans by Region**

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

**5. Specialty plans** are designed for a specific population such as, 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).

# IV. Budget Neutrality

The State is required to provide an estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request. Budget neutrality compliance for the entire waiver is provided in Section V of the waiver extension request. The MMA Waiver extension can be found at the link provided on page 2 of this document.

**Budget Neutrality – Amendment**

There is no material impact on budget neutrality as a result of assigning Medicaid-eligible individuals who are mandated to participate in Florida's MMA program to a managed care plan immediately after eligibility determination.

# V. Quality Initiatives

A comprehensive description of the State's quality initiatives can be found in Section VI of the waiver extension. The link to the waiver extension is provided on page 2 of this document. The State is measuring plan performance by requiring the MMA plans to collect and report the following performance measures, certified via qualified auditor. Table 10 lists the MMA plan performance measures by measure steward/source. Performance measure reporting is based on all enrolled members (or a random sample of them) who meet the eligibility criteria for each performance measure, so if enrollees in the (proposed) newly added populations meet the eligibility criteria for a measure, they will be included in the performance measure calculation.

| Table 10<br>HEDIS Plan Measures | |
|---|---|
| 1 | Adolescent Well Care Visits – (AWC) |
| 2 | Adults' Access to Preventive/Ambulatory Health Services – (AAP) |
| 3 | Annual Dental Visits – (ADV) |
| 4 | Antidepressant Medication Management – (AMM) |
| 5 | BMI Assessment – (ABA) |
| 6 | Breast Cancer Screening – (BCS) |
| 7 | Cervical Cancer Screening – (CCS) |
| 8 | Childhood Immunization Status – (CIS) – Combo 2 and 3 |
| 9 | Comprehensive Diabetes Care – (CDC)<br>· Hemoglobin A1c (HbA1c) testing<br>· HbA1c poor control<br>· HbA1c control (<8%)<br>· Eye exam (retinal) performed<br>· LDL-C screening<br>· LDL-C control (<100 mg/dL)<br>· Medical attention for nephropathy |
| 10 | Controlling High Blood Pressure – (CBP) |
| 11 | Follow-up Care for Children Prescribed ADHD Medication – (ADD) |
| 12 | Immunizations for Adolescents – (IMA) |
| 13 | Chlamydia Screening for Women – (CHL) |
| 14 | Prenatal and Postpartum Care – (PPC) |
| 15 | Use of Appropriate Medications for People With Asthma – (ASM) |
| 16 | Well-Child Visits in the First 15 Months of Life – (W15) |
| 17 | Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34) |
| 18 | Children and Adolescents' Access to Primary Care – (CAP) |
| 19 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment |
| 20 | Ambulatory Care – (AMB) |
| 21 | Lead Screening in Children – (LSC) |
| 22 | Annual Monitoring for Patients on Persistent Medications – (MPM) |
| 23 | Plan All-Cause Readmissions (PCR) |
| **Agency-Defined** | |
| 1 | Mental Health Readmission Rate – (RER) |
| 2 | Transportation Timeliness – (TRT) |
| 3 | Transportation Availability – (TRA) |

| Table 10<br>HEDIS Plan Measures | |
|---|---|
| **HEDIS & Agency-Defined** | |
| 1 | Follow-Up after Hospitalization for Mental Illness – (FHM) |
| 2 | Prenatal Care Frequency – (PCF) |
| **Health Resources and Services Administration – HIV/AIDS Bureau** | |
| 1 | CD4 Cell Count – (CD4) |
| 2 | Viral Load Monitoring – (VLM) |
| 3 | Antiretroviral Therapy – (ART) |
| 4 | Viral Load Suppression – (VLS) |
| **CHIPRA Child Core Set/Child Health Check Up Report (CMS-416)** | |
| 1 | Preventive Dental Services – (PDENT) |
| 2 | Dental Treatment Services – (TDENT) |
| 3 | Sealants – (SEA) |
| **CMS Adult Medicaid Core Set/Joint Commission** | |
| 1 | Antenatal Steroids – (ANT) |
| **CAHPS Health Plan Survey** | |
| 1 | Medical Assistance with Smoking and Tobacco Use Cessation |

In addition, the MMA plans that serve children only (Child Welfare Specialty Plan and Children's Medical Services Plan) are not be required to report on performance measures specific to adults. These plans are required to report on additional children's measures listed in Table 11.

| Table 11<br>CHIPRA Child Core Set | |
|---|---|
| 1 | HPV Vaccine for Female Adolescents – (HPV) |
| 2 | Medication Management for People with Asthma – (MMA) |
| 3 | Developmental Screening in the First Three Years of Life – (DEVSCR) |
| **AHRQ-CMS CHIPRA National Collaboration for Innovation in Quality Measurement (NCINQ)** | |
| 1 | Children on Higher than Recommended Doses of Antipsychotics (HRDPSY) |
| 2 | Use of Antipsychotics in Very Young Children (PSYVYC) |
| 3 | Use of Multiple Concurrent Antipsychotics in Children (CONPSY) |

# VI. Evaluation Status and Findings

The status and findings of the evaluation for the entire demonstration are provided in Section VII of the waiver extension. The waiver extension can be found at the link provided on page 2 of this document. The Agency is working with Federal CMS to make any needed updates to the evaluation design, comprehensive quality strategy or the oversight, monitoring and measurement of the provisions previously outlined in the MMA Waiver extension document.

Evaluation Design – Amendment

The Agency is working with Federal CMS to complete a final evaluation design of the entire demonstration for the waiver extension period ending June 30, 2017. Upon federal approval and implementation of this amendment, the State will assess the extent to which the new enrollees who are enrolled in an MMA plan immediately after eligibility determination impact the evaluation design, and determine whether and how the evaluation design should be adjusted.

# VII. Waiver and Expenditure Authorities

The State is not requesting any changes to the waiver authorities or expenditure authorities authorized July 31, 2014. The State is requesting to amend Special Term and Condition #21, #22, and #40 of the MMA Waiver to remove the 30-day delay period between eligibility determination and managed care plan enrollment for Medicaid-eligible individuals who are mandated to participate in the MMA program. New enrollees will continue to receive 30 days to select a managed care plan after being determined eligible for Medicaid, prior to the 90-day disenrollment period. The STCs of the MMA waiver can be found at the link provided on page 3 of this document.

Appendix B is the Waiver Authorities document and Appendix C is the Expenditure Authorities document of the MMA Waiver as approved by Federal CMS July 31, 2014.

# Appendix A
# Letters to the Miccosukee Tribe and the Seminole Tribe

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 25, 2015

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

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida that the State of Florida plans to submit an amendment to Florida's 1115 Managed Medical Assistance (MMA) Waiver to the Centers for Medicare and Medicaid Services (CMS). The proposed amendment will allow recipients who are mandatory for enrollment in the MMA program to be enrolled in an MMA managed care plan immediately upon being determined eligible for Medicaid.

The Agency for Health Care Administration (Agency) will conduct a 30-day public notice and comment period prior to the submission of the proposed amendment request to CMS. The 30-day public notice and public comment period will begin March 27, 2015 and end April 26, 2015. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendment from the public.

The first meeting will be held on Tuesday, April 7, 2015, from 1:00 p.m. to 3:30 p.m. at the Agency for Health Care Administration, 6800 North Dale Mabry Highway, Main Training Room, Tampa, FL 33614. The second meeting will be held on Tuesday, April 14, 2014, from 3:00 p.m. to 5:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Dr., Building 3, Conference Room A, Tallahassee, Florida 32308.

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

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/hm

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 25, 2015

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

Dear Ms. Whidden:

This letter is being sent to notify the Seminole Tribe of Florida that the State of Florida plans to submit an amendment to Florida's 1115 Managed Medical Assistance (MMA) Waiver to the Centers for Medicare and Medicaid Services (CMS). The proposed amendment will allow recipients who are mandatory for enrollment in the MMA program to be enrolled in an MMA managed care plan immediately upon being determined eligible for Medicaid.

The Agency for Health Care Administration (Agency) will conduct a 30-day public notice and comment period prior to the submission of the proposed amendment request to CMS. The 30-day public notice and public comment period will begin March 27, 2015 and end April 26, 2015. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendment from the public.

The first meeting will be held on Tuesday, April 7, 2015, from 1:00 p.m. to 3:30 p.m. at the Agency for Health Care Administration, 6800 North Dale Mabry Highway, Main Training Room, Tampa, FL 33614. The second meeting will be held on Tuesday, April 14, 2014, from 3:00 p.m. to 5:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Dr., Building 3, Conference Room A, Tallahassee, Florida 32308.

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

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/hm

# Appendix B
# Waiver Authorities

**WAIVERS FOR FLORIDA'S**
**MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION**

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

**TITLE: Managed Medical Assistance Program**

**AWARDEE: Agency for Health Care Administration**

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

The following waivers are granted under the authority of section 1115(a)(1) of the Social Security Act (Act) and shall enable the state to implement the Florida Managed Medical Assistance Program section 1115 demonstration (formerly titled Medicaid Reform) consistent with the approved Special Terms and Conditions (STCs). These waivers are effective beginning July 31, 2014, through June 30, 2017.

**Title XIX Waivers**

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

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

**2. Amount, Duration, and Scope and Comparability** **Section 1902(a)(10)(B) and 1902(a)(17)**

To enable Florida to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, based on differing managed care arrangements, or in the absence of managed care arrangements, as long as the benefit package meets certain actuarial benefit equivalency and benefit sufficiency requirements. This waiver does not permit limitation of family planning benefits. (Also this waiver is to permit Florida to offer different benefits to demonstration Population A than to the categorically needy group, through June 30, 2015.)

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

To enable Florida to exclude funds in an enhanced benefit account from the income and resource tests established under state and federal law for purposes of determining Medicaid eligibility. This authority expires on June 30, 2015.

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

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

# Appendix C
# Expenditure Authorities

## EXPENDITURE AUTHORITIES FOR FLORIDA'S MANAGED MEDICAL ASSISTANCE SECTION 1115 DEMONSTRATION

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

**TITLE: Managed Medical Assistance Program**

**AWARDEE: Agency for Health Care Administration**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration from July 31, 2014, through June 30, 2017, be regarded as expenditures under the state's Title XIX plan.

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

1. **Demonstration Population A.** Expenditures for health care related costs not to exceed the amount of the individual's enhanced benefit account, for individuals who lose eligibility for Medicaid or demonstration Population A benefits. This expansion population shall be allowed to retain access to the enhanced benefits account for up to 1 year, except in the instance of termination of the demonstration. This authority expires June 30, 2015.

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

3. Expenditures made by Florida for uncompensated care costs incurred by providers for health care services to uninsured and or underinsured, and associated projects to support such care, subject to the restrictions placed on the Low Income Pool, as defined in the STCs. This authority expires June 30, 2015.

4. Expenditures for benefits under the enhanced benefits account program. This authority expires June 30, 2015.

5. Expenditures for the Program for All Inclusive Care for Children services and the Healthy Start program as previously approved under the 1915(b) waiver (control #FL-01) and as described in STCs 64 and 65.

**Medicaid Requirements Not Applicable to the Expenditure Authorities:**

Through June 30, 2015, in order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authorities described above, the following Medicaid requirements are not applicable to the expenditure authorities:

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

To enable Florida to limit the medical assistance for demonstration Population A (individuals who lose eligibility for Medicaid or demonstration Population A benefits) to health care related costs not to exceed the amount of the individual's enhanced benefit account.

**2. Amount, Duration, and Scope and Comparability** **Section 1902(a)(10)(B) and 1902(a)(17)**

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

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

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

# Appendix D
# Sample Letter

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

*<Payee Name>*
*<Addr-Line1>*
*<Addr-Line2 >*
*<City> <State> <Zip Code>*

*<Letter Date>*

0000000123

As Medicaid recipients, each person listed below will receive their health care services through the Managed Medical Assistance (MMA) program, a part of Statewide Medicaid Managed Care. Follow steps 1-3 below to make a choice.

**IMPORTANT: Each person listed on this letter is currently enrolled with the plan listed below. The start date for this enrollment is also listed below.**

**Plan Name:** <Managed Medical Assistance Plan> **Plan Start Date:** <effective>

**To gain quicker access to your case, please use the following security PIN to enroll:** <PIN#>

Step 1: ***Look***

Look at the information in this packet. It includes:

- information on the MMA program
- a list of the plan(s) in your region
- a list of the extra benefits offered by the plan(s)
- the steps you need to take to change your plan
- how to enroll online or by phone
- answers to frequently asked questions

You can also find this same information online at: www.flmedicaidmanagedcare.com

Step 2: ***Choose***

**You have rights to change plans. See the back of this letter for Your Rights to Change Plans.**

| Name | Medicaid # |
|---|---|
| <Name> | <Medicaid ID> |

**You may change MMA plans for each person listed in this letter from the plan listed below, if you wish.**

**For each person, you will need:**

- birth date **and**
- either the Medicaid number or Social Security Number.

Step 3: ***Change***

**Online** **OR** **Call**

www.flmedicaidmanagedcare.com

**Please note:** If you choose to make changes online you will need to use the Security PIN above. The PIN must be used along with your Medicaid ID or Gold Card number.

Toll-free at 1-877-711-3662 to talk to a choice counselor or request to meet with a choice counselor.

For additional information, please see the brochure in your packet.

**See the back for Your Rights to Change Plans.**

Return Address: Agency for Health Care Administration 2727 Mahan Drive, MS 62 Tallahassee, FL 32308
Call Center Hours: Monday-Thursday - 8 a.m. - 8 p.m.; Friday - 8 a.m. - 7 p.m. TTY/TDD users ONLY call 1-866-467-4970
If you need Choice Counseling materials in large print, audio or Braille, call the Toll-free Helpline 1-877-711-3662.

# Appendix D
# Sample Letter

## YOUR RIGHTS TO CHANGE PLANS

Your enrollment with your plan starts **<Insert dynamic start date>.** You have until **<Insert dynamic 120 day cut-off date>** to change you plan. Any change made will begin the first of the following month.

After this date, if you want to change your plan, you can do so once a year during a special time called Open Enrollment. Before your Open Enrollment period begins, you will receive a reminder letter and information about your plan choices.

If you want to change plans at a time other than during Open Enrollment, you must have a state-approved good cause reason. For more information or to find out if you have a good cause reason, call 1-877-711-3662 or visit www.flmedicaidmanagedcare.com.

# Florida Managed Medical Assistance Program
# 1115 Research and Demonstration Waiver
(Project Number 11-W-002064)

# Replacement Sections
**Waiver Amendment Request**
**Submitted May 4, 2015**

**Posted on Agency Website**
http://ahca.myflorida.com/medicaid/statewide_mc/mma_fed_auth.shtml

**Florida Agency for Health Care Administration**

# I. Purpose, Goals and Objectives

## E. Waiver Amendment Requirements

The State will submit the MMA Waiver amendment to Federal CMS in accordance with STCs #7 and #15 of the MMA waiver and 42 Code of Federal Regulations (CFR) 431.408. The following is a description of the required public notice document.

Public Notice Document: The State is posting this "Public Notice" document to solicit public input 30 days prior to submission of the amendment request to Federal CMS. This public notice document is required to include a comprehensive description of the amendment application that contains sufficient detail to ensure meaningful input from the public, including:

(A) Demonstration of Public Notice 42 CFR §431.408 and tribal consultation: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 and documentation that the tribal consultation requirements outlined in STC 15 have been met.

(B) Demonstration Amendment Summary and Objectives: The state must provide a detailed description of the amendment, including; what the state intends to demonstrate via the amendment as well as impact on beneficiaries with sufficient supporting documentation, the objective of the change and desired outcomes including a conforming Title XIX and/or Title XXI state plan amendment, if necessary.

(C) Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested for the amendment.

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

(E) An up-to-date CHIP allotment neutrality worksheet, if necessary; and

(F) Updates to existing demonstration reporting, quality and evaluation plans: A description of how the evaluation design, comprehensive quality strategy and quarterly and annual reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provision.

# IV. Budget Neutrality

The State is required to provide an estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable. This includes a financial analysis of any changes to the demonstration requested by the State in its extension request. Budget neutrality compliance for the entire waiver is provided in Section V of the waiver extension request. The MMA Waiver extension can be found at the link provided on page 2 of this document.

**Budget Neutrality - Amendment**

There is no material impact on budget neutrality as a result of assigning Medicaid-eligible individuals who are mandated to participate in Florida's MMA program to a managed care plan immediately after eligibility determination.

The current 1115 MMA budget neutrality accounts for member months and expenditures for both the mandatory and the voluntary populations in the MMA waiver program. Currently, new Medicaid recipients who enroll in the MMA program remain in fee for service for some time while awaiting enrollment in a managed care plan. For these individuals, expenditures included in the budget neutrality calculations account for both the FFS expenditures incurred prior to plan enrollment, as well as the capitation expenditures after plan enrollment. The proposed amendment assigns Medicaid-eligible individuals who are mandated to participate in the MMA program, into a MMA managed care plan immediately after eligibility determination, and thus eliminates the period during which the state pays FFS expenditures. Express enrollment is not expected to increase or decrease the annual MMA enrollment nor aggregate expenditures; therefore, the MEG1 and MEG2 Per Member Per Month (PMPM) costs should remain unchanged for the 1115 MMA Demonstration, with waiver and without waiver.

# VI. Evaluation Status and Findings

The status and findings of the evaluation for the entire demonstration are provided in Section VII of the waiver extension. The waiver extension can be found at the link provided on page 2 of the May 4, 2015 Waiver Amendment Request. Updates on the status of the evaluation will be provided in the quarterly and annual reports to CMS. Once approved, the quarterly and annual reports will be modified to reflect these additions.

Evaluation Design – Amendment

The Agency is working with CMS to complete a final evaluation design of the entire demonstration for the waiver extension period ending June 30, 2017. The Agency proposes adding the following research questions, hypotheses, analyses and data sources to Domain 1 of the evaluation design to measure the impact of enrolling recipients into a health plan immediately after eligibility determination:

| Domain | Research Questions | Hypotheses | Analyses | Data Sources |
|---|---|---|---|---|
| **Domain 1** The effect of managed care on access to care, quality and efficiency of care, and the cost of care. | 1.K.<br><br>How quickly do recipients access services, including expanded benefits in excess of State Plan covered benefits, after becoming Medicaid eligible if they are enrolled in a health plan immediately upon becoming Medicaid eligible compared to those recipients who experienced a period of fee-for-service enrollment prior to health plan enrollment. | 1.K.<br><br>It is expected that recipients will access services sooner if they are enrolled in a health plan immediately upon becoming Medicaid eligible. This includes both State Plan benefits and expanded benefits in excess of State Plan coverage. | Comparison of timing of use of services by enrollees who were enrolled in fee-for-service Medicaid prior to enrolling in an MMA health plan to those enrollees who were enrolled in a MMA health plan immediately after eligibility determination. | Medicaid claims; eligibility, enrollment and encounter data. |

Amendment Impact on Comprehensive Quality Strategy

The state's Comprehensive Quality Strategy (CQS) will incorporate a description of the changes to the enrollment process and how they improve access to care for recipients.

**From:** Lori Hairston
**Sent:** Thursday, March 26, 2015 7:39 AM
**To:** FLMedicaidWaivers
**Subject:** Question regarding Florida's 115 MMA Waiver amendment request

Good morning, I have a question regarding the below information regarding the proposed amendment request. My apology if it will be addressed in the meeting.

During the initial 30-day period post-enrollment, if a recipient decides to change plans, the change will take effect the first day of the following month. The 30-day change period will be followed by a 90-day disenrollment period. During the 90-day disenrollment period, if a recipient decides to change plans, the change will take effect the first day of the following month.

1. How many times in the 30-day period post enrollment is the recipient allowed to change plans?
2. If a recipient changes plan, does the 30-day period post enrollment start over with each change?
3. How many times during the 90-day disenrollment period can a recipient change plans?
4. If a recipient changes plans during the 90-day disenrollment period, does the 90-day disenrollment period start over with each change?

Thank you for the opportunity to ask questions. I look forward to the meeting.

---

**From:** Margaret Campbell
**Sent:** Thursday, March 26, 2015 3:17 PM
**To:** FLMedicaidWaivers
**Subject:** '1115 MMA Waiver Amendment Request'

Please discuss how this will effect our Medicaid Hospice Beneficiaries. Will this immediate enrollment apply for both community hospice and nursing home hospice cases? The MMA's are the primary providers for our nursing home beneficiaries enrolled under Hospice.

---

**From:** Gloria Lopez
**Sent:** Sunday, March 29, 2015 5:32 PM
**To:** FLMedicaidWaivers
**Subject:** '1115 MMA Waiver Amendment Request'

I am in favor of the amendment to remove the 30-day period between eligibility determination and managed care plan enrollment and to amend the auto-assignment criteria. I think patients should be able to pick their plan and their doctors.

---

**From:** Jill Renuart
**Sent:** Wednesday, April 1, 2015 10:40 AM
**To:** FLMedicaidWaivers
**Subject:** 1115 MMA Waiver Amendment Request

I am writing from a pediatric primary care office which has accepted Medicaid patients for 14 years, employs 4 Medicaid providers and sees thousands of Medicaid patients each year. Regarding the state's auto-assignment procedures, I would like to mention that the patient's current MMA plan should be considered when auto-assigning them after the eligibility determination period.

We are having a problem with our patients who have been enrolled in a MMA plan since June 2014, (when MMA was rolled out in Area 6) and when they have reapplied for Medicaid, they are being assigned to a different MMA plan than their original plan without their knowledge. This is a problem because the patient might be on a plan for which their primary care is a provider for, but may not be accepting new patients. OR the patient may have been assigned to a plan which their primary care accepts, but their specialist does not accept or their medication is not on the new plan's formulary. Often, the patients don't realize the impacts of a plan change.

I assume they were auto-assigned after their reapplication, but unless the patient requests a change, they should be assigned to the same MMA as they had before.

---

**From:** Patricia McWhirter
**Sent:** Monday, April 6, 2015 5:59 PM
**To:** FLMedicaidWaivers
**Subject:** 1115 MMA Waiver Amendment Request

Dear AHCA Team:

Thank you for the opportunity to comment on the proposed 1115 MMA Waiver amendment. I am writing as our program serves pregnant women, who would like to retain their prenatal care physician when going into Florida's Medicaid managed care under MMA. During the nine months of pregnancy it is ideal to keep prenatal care as consistent as possible, especially for women who are deemed at risk for poor birth outcomes. An involuntary assignment to a managed care plan, by disrupting continuity of health care during critical months, could be menacing to the health of these clients.

From your recent alert, "Request to Amend Florida's 1115 MMA Waiver Public Meetings (Revised)" notice, it reads:

> "The proposed amendment will allow individuals to be enrolled in a managed care plan immediately after eligibility determination. Under the proposed amendment, **individuals will receive both their managed care plan assignment** and information about the managed care plan choices in their area, to encourage an active selection, immediately after eligibility determination.
>
> During the initial 30-day period post-enrollment, if a recipient decides to change plans, the change will take effect the first day of the following month. The 30-day change period will be followed by a 90-day disenrollment period. During the 90-day disenrollment period, if a recipient decides to change plans, the change will take effect the first day of the following month."

**Question:**

**Since the individual would receive their "managed care plan assignment" and information about the "managed care plan choices," does this mean the individual is being auto assigned immediately? Thus, leaving the client out of the preliminary choice cycle, but then allowing them to change from the assigned plan for the next month?**

**If they are immediately "assigned" a plan, without a choice up front, this would seem to violate Florida Statutes 409.977 (1) and 409.969 (1):**

**409.977 Enrollment.—**

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients **who do not voluntarily choose a plan pursuant to s. 409.969**.

**409.969 Enrollment; disenrollment.—**

(1) ENROLLMENT.— All Medicaid recipients shall be enrolled in a managed care plan unless specifically exempted under this part. **Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Medicaid recipients shall have 30 days in which to make a choice of plans.**

---

**From:** Poonam Rangwala
**Sent:** Tuesday, April 7, 2015 1:43 PM
**To:** FLMedicaidWaivers
**Subject:** 1115 MMA Waiver

If we have a recipient where Medicaid eligibility is being seeked retroactively as the application was submitted a month back, when patient is approved, will the MMA plan be effective the month of approval or the month approval has been received.

Example:

1. Patient admitted to Hospice on 02/01/15. Hospice application has been submitted.
2. Approval received from Medicaid on 03/01/15 with retroactive eligibility eff 02/01/15.
3. Will MMA plan be assigned eff 02/01/15 or 03/01/15?

---

**From:** Joan Gentile
**Sent:** Tuesday, April 7, 2015 3:34 PM
**To:** FLMedicaidWaivers
**Subject:** 1115 MMA Waiver Amendment Request

I work with individuals with traumatic brain and spinal cord injuries. I have a couple of concerns regarding adequate provider networks with the managed care plans. I realize that in

order to access specialty care a patient may need to travel out of area. However, the specialty care provider network has been lacking in all of the managed care plans servicing, Glades, Hendry, Lee, Charlotte and Collier counties. Patients must travel to Miami or the Tampa area. Transportation is provided by the Managed care plans, however, for some of these patients the commute is 6 hours round trip, and puts them at risk for further medical complications. In addition, all of the local MMA plans are using Univita as the clearing house for Durable Medical Equipment, ventilators, wound care, home health care. Univita is not timely in providing these basic essential services for patients. Univita should be held accountable as a subcontractor to the MMA and the MMA as well for these contracted services. If Univita is unable to fill contractual obligations to the MMA then another alternative must be found. Patients are having to wait several months for wheelchair authorizations, putting them at risk for further medical complications from ill-fitting loaner wheelchairs. It is extremely difficult to get medically necessary DME authorized particularly hospital beds and air loss mattresses to prevent or maintain pressure sore prevention. Other necessary medical supplies have also been more difficult for patients to obtain (urinary catheters) via MMA and Univita. I feel these issues need to be addressed as they pose health and safety risks for patients.

---

**From:** Margaret Campbell
**Sent:** Wednesday, April 8, 2015 8:59 AM
**To:** FLMedicaidWaivers
**Subject:** 1115 MMA Waiver Amendment Request

This are questions concerning Hospice Medicaid Applicants:

- When will a letter stating plans to be chosen be generated once the online application is entered on ACCESS? (as soon as app goes in or right before approval is given?) ***we want to make sure our patient's have enough time to choose a plan*** Or this will NOT be an option?

- Am I understanding that once the NOCA has been generated that if a managed plan has NOT been chosen then that is when the state will choose a plan for the approved recipient?

- After they are locked after the 120 days (if they move out of service area) are they able to enroll in another plan?

---

**From:** Patty McWhirter
**Sent:** Tuesday, April 14, 2015 1:19 PM
**To:** FLMedicaidWaivers
**Subject:** 1115 MMA Waiver Amendment Request

Thank you for this opportunity. In the Healthy Start program, we serve pregnant women and infants who are at risk for a poor birth or developmental outcome. Under the proposed amendment, I understand that a client may choose their managed care plan before their Medicaid eligibility is determined. I have heard that their plan choice cannot be retroactive, but in those circumstances, the Medicaid status would be fee for service.

What would the client's managed care plan status be as of the first month of eligibility?

---

**From:** Reina Lombardi
**Sent:** Monday, April 20, 2015 11:09 AM
**To:** FLMedicaidWaivers
**Subject:** 1115 MMA Waiver Amendment Request

To Whom It May Concern:

Hello. I am writing to request a revision of hiring standards for art therapists. At current, the state of Florida does not have a license for art therapists. While I decided to pursue the LMHC in the state so that I can provide services, many other art therapists do not/have not. Though our professional organization is working hard to establish such legislation, it is a time consuming process and there are no guarantees. By requiring the art therapist to have a state issued license to provide art therapy services, many clients are unable to obtain such services if the art therapists in their locale hold the Registered Art Therapist (ATR) or Board Certified Registered Art Therapist (ATR-BC) credentials which qualify them to provide art therapy services, but not a state license. Please consider revising hiring standards to reflect the lack of Florida licensure for art therapists. Please feel free to contact me with any questions or concerns.

---

**From:** Annie Draper
**Sent:** Monday, April 20, 2015 2:59 PM
**To:** FLMedicaidWaivers
**Subject:** 1115 MMA Waiver Amendment Request

I am writing to make a suggestion regarding insurance reimbursement for art therapy services. In the state of Florida, there is currently no license for art therapists. Many of the insurance companies that are interested in working with art therapists are not reimbursing/not hiring art therapists because of lack of licensure in the state. Currently, Master's level art therapists may become Registered or Board Certified at the national level. Hiring standards need to be revised to reflect the reality of not having a license for art therapists in Florida.

Thank you for your help in resolving this matter,

---

FAHP FLORIDA ASSOCIATION OF HEALTH PLANS, INC.
*Representing Florida's Health Plans*

**www.fahp.net 200 West College Ave, Suite 104, Tallahassee, Florida 32301 (850) 386-2904**

April 24, 2015
Justin Senior, Deputy Secretary for Medicaid

Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
Re: Request to Amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-002064)

Dear Mr. Senior:

In response to the Agency for Health Care Administration (Agency) request for public input on a proposed amendment to Florida's 1115 Managed Medical Assistance (MMA) Waiver, I am writing on behalf of the Florida Association of Health Plans (FAHP) and its member plans to offer input with regard to the impact of the proposed amendment.
Many of our member health plans participated in public meetings held April 7 and April 14 and have carefully reviewed the following information provided in the revised provider alert released by the Agency on March 27, 2015:

"The State is requesting this amendment to remove the 30-day period between eligibility determination and managed care plan enrollment and to amend the auto-assignment criteria to conform to Section (s.) 409.977(2), Florida Statutes, which states:
"When automatically enrolling recipients in managed care plans, the agency shall automatically enroll based on the following criteria: (a) Whether the plan has sufficient network capacity to meet the needs of the recipients. (b) Whether the recipient has previously received services from one of the plan's primary care providers. (c) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.
The proposed amendment will allow individuals to be enrolled in a managed care plan immediately after eligibility determination. Under the proposed amendment, individuals will receive both their managed care plan assignment and information about the managed care plan choices in their area, to encourage an active selection, immediately after eligibility determination.

During the initial 30-day period post-enrollment, if a recipient decides to change plans, the change will take effect the first day of the following month. The 30-day change period will be followed by a 90-day disenrollment period. During the 90-day disenrollment period, if a recipient decides to change plans, the change will take effect the first day of the following month."
After careful review of the impact of these stated changes and the proposed amendment to the 1115 MMA Waiver, our member health plans wish to offer the following comments and questions:

COMMENTS:
The entire concept of in-month enrollment presents a whole host of logistical challenges for plans, including administrative as well as financial/actuarial issues and concerns. From an administrative perspective, health plans will experience higher disenrollments as a result of this change which could harm the reputation of the health plan. In addition, plans will experience unnecessary expenses related to member materials and return mail.

We understand that members can change plans frequently (even daily?) during initial enrollment under this new model. If so, it will be critical for the Agency to clearly communicate how this will work so the plans understand it thoroughly and are afforded adequate time prepare for it. Likewise, the change in auto-assignment logic (migrating away from the primacy of historical plan relationship in deference to PCP affiliation), as well as, the secondary considerations of current LTC plan and MCR plan affiliation, are also important elements for plans to understand.

Further clarification is also needed as to whether the express enrollment amendment applies to the Medicaid specialty plans as well. If express enrollment does apply to specialty plans, we ask that AHCA define the span of coverage. For example, this process would be beneficial to enrollees within the Child Welfare Specialty Plan but prompts operational questions such as if a child is inpatient when eligibility is determined, is the Health Plan responsible for the inpatient costs or just the professional/outpatient services from the date of eligibility?

It is recommended that consideration be given to excluding other specialty plan recipients from the auto-assignment/30 day change period. There is a tremendous amount of coordination that goes into on-boarding recipients such as medically complex and SIPP recipients, pregnant enrollees, and many recipients eligible for a specialty plan. Greater consideration needs to be given to these recipients when placing them in a plan outside of the criteria indicated in the statute.

From a financial/actuarial perspective, challenges include the following:

1) If the Agency removes the 30 day MCO selection period, the Agency will need to include in the capitation rate development for 9/1/15 the historic FFS claims for these populations that will now participate under Managed Care. We do not expect that these member's claims will look similar to the current population in the early months of their eligibility due to pent-up demand. Additionally, rates will need to be developed using pro-rated member months so as not to overstate the rate development denominator and thus understate the PMPM cost. Transparency in the rate development process is key to ensuring the capitation rates are adjusted appropriately.

2) Plans need confirmation from the agency that "Express Enrollment "does not include presumptive eligibles. If those presumptive eligible are included in the process, then a separate rate cell will need to be developed due to the nature of their current condition - higher risk, hospital based members.
3) Payment system issues also present challenges. Plans that pay providers monthly capitation, for example, will need to reconcile or prorate payment to providers, etc.

In addition, the proposed 1115 waiver amendment has prompted the following questions from our member health plans:

QUESTIONS:

1) What does the eligibility cycle look like? For example, if an individual is deemed eligible on the 8th of the month is their eligibility retro-active to the first of the month or prospective to the first of the following month? What if eligibility falls at the end of the month; 24th? Would the individual be assigned as of the 1st of the next month or the subsequent month? If there are cut off dates, plans will need to know what they are.

2) Would the recipient's eligibility go into effect the next business day after eligibility determination? If so would the recipient become effective with a Plan on the next business day? Will the recipient's Plan effective date and selection appear in FMMIS on the same day the member became Medicaid eligible?

3) If a recipient changed Plans on the last day of the month would the effective date with the new Plan be the next month or the following month?

4) Will assignments only be effective the 1st of the month or will there be scenarios for effective dates outside of the 1st? If so, please describe the scenarios.

5) Will all the same requirements for coordination of care and continuity of care be required during the 30 day change period? If so, continuity of care would expire at the end of the first month of the 90 day disenrollment period, correct?

6) How will disenrollment within the change period be reflected on the eligibility file?

7) Can an individual pick the plan they want at the time they are deemed eligible, thereby waiving the 30 day change period and moving straight to the 90 day disenrollment period?

8) What type of managed care plan information will be distributed to eligible individuals during the 30 day change period?

9) Will plans have the ability to outreach to members during this 30 day change period to provide additional plan information and materials related to benefits?

10) If a member is enrolled at eligibility and eligibility is determined by DCF, what Plan selection assistance would be offered to the recipient? What role would DCF play and what role would Choice Counseling play? Would the DCF and Choice Counseling work collaboratively? If so how?

11) Realizing the MMA rates must be actuarially sound what type of rate methodology will Milliman use to determine the rates for members that are assigned to the Plans for a partial month?
12) Will plans receive a full month of capitation for the 30 day change period?

Thank you for the opportunity to provide input on the impact of the proposed amendment to Florida's 1115 MMA Waiver. The FAHP and its members appreciate your consideration and look forward to your response. We are committed to continuing our shared efforts to ensure the highest quality of care and access for Floridians.
Sincerely,
Audrey Brown
FAHP President and CEO

Freedom Pharmacy & Wellness Center

HHCS *Health Group* of Companies

Cystic Fibrosis Pharmacy

April 23, 2015

115 MMA Waiver Amendment Proposal

Office of the Deputy Secretary for Medicaid

Agency for HEALTH CARE Administration

2727 Mahan Dr. MS# 8

Tallahassee, Florida 32308

This letter is in response to your request for Public Comments regarding the 1115 MMA Medicaid Waiver request.

The mission of this demonstration is to improve medical outcomes through care coordination and patient engagement in their own healthcare while maintaining fiscal responsibility. The state is commissioned to provide oversight focused on improving access and increasing quality of care. If this is true, then the state should provide more oversight over the selection and monitoring of the health program or go back to fee-for-service for those with complex illnesses such as cystic fibrosis. This diagnosis was not included in the fee for service Medicaid program as somehow they were not included in whatever hearing was held to determine this. In fact, I did not know about these hearings and I shall expect to advocate and represent over 100 patients with this issue in meetings in June with the legislature and the governor.

After having provided medical and pharmacy services in the state of Florida for in excess of 50 years, it has become very clear that the Managed Medicaid program does not provide exceptional medical services for our Medicaid population of the sickest patients and it shows how our money has been thoughtlessly wasted.

As a pharmacist professional and pharmacy owner, I have seen instance after instance where patients could not get the medications that they needed which had been ordered for them and the oversight of medical care by unqualified personnel of the Medicare/Medicaid

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Advantage plans with their prior authorization has done nothing but increase the costs to the physician because of the need for additional personnel and the pharmacy which has had to deny provision of medications which are considered to be "gold standard" to patients with difficult, hard to treat complex illnesses.

Further, Prescription Benefits Managers (PBM) whose purpose it was to only process prescriptions for insurance companies, now actually control what medications will be available, what THEY believe the physician should prescribe and how much in rebates they will get from manufacturers and insurers The employer and the insured has no control over the kind of medicine that the patient MAY receive and the pharmacy (unless owned by the big-box stores and their conveyor belt mentality with their own PBM's) , is in danger of being excluded by the PBM pharmacy networks if they report anything to those wishing to take issue with this practice.

There is no accountability by the PBMs to anyone- not to any official or agency of this state- to monitor their practices. They are being successful in driving the independent pharmacist out of business in this state. They are also costing the state many dollars in their 90-day "financially feasible" supply of medicines especially since over 1017 TONS of medicine was collected during DEA "takeback" days in a little over a year. Yes, our state paid its share for that unnecessary medicine which had to be destroyed

As a citizen and taxpayer in the State of Florida, I am appalled that we are sending any profits made out of state instead of supporting the citizens of Florida where the money is so needed.

Medicaid as an insurance fails in many ways not the least of which is lack of access to care. Insurance for the poor and disadvantaged may be a good concept but we have a DENIAL OF ACCESS TO CARE and there my friends, is how this the people of this state are getting taken advantage of, how the real costs of care continue to escalate, why many physicians will not see Medicaid patients, and how this program is driving the independent pharmacy who actually provides care out of business.

The issue should not be to Amend the Managed Medicaid Program Waiver but to end it and with good oversight, include those of us who have taken care of patients in a cost effective

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manner along with the clinicians who are operating under unreasonable regulations and conditions treat these people under a fair Fee-for- Service Program.

Please let me know if you would like to have me present a fair program where all of the people in this state will benefit. My Curriculum Vitae is attached.

Very truly yours,

HHCS HEALTH GROUP OF COMPANIES

N. Lois Adams, Consultant Pharmacist/MBA

President/CEO

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