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

Waiver Amendment Request

Posted on Agency Website
http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_amend_waiver_2016-01.shtml

Florida Agency for Health Care Administration

This page intentionally left blank.

Table of Contents

List of Tables

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 make the following changes:

- Amend the waiver to allow the Agency for Health Care Administration (Agency) flexibility to contract with 1-3 vendors under the hemophilia program. This will allow the State more flexibility to procure the highest-quality, most efficient and lowest cost vendors.

- Amend the waiver to include payment for nursing facility services in MMA capitation rates for recipients under the age of 18 years.

  The majority of these children are enrolled in an MMA plan. As such, the plan is responsible for coordinating the enrollee's care and for paying for any medical care not included in the nursing facility per diem rate. Requiring MMA plans to pay for and provide this service for children under the age of 18 years will eliminate a payment carve out and ensure that MMA plans are accountable for and incentivized to provide:

  - Comprehensive discharge planning; and
  - Community-based options and supports for children under the age of 18 years to transition safely from the nursing facility.

- Amend the waiver to allow flexibility for specialty plans to conduct Performance Improvement Projects (PIPs) on other topics that have more impact on their enrollees, with Agency approval. The two mandatory PIPs included in Special Terms and Conditions (STC) #108 are Improving Prenatal Care and Well-child Visits in the First 15 Months and Preventive Dental Care for Children.

  There are four MMA Specialty plans that are focused on specific health conditions and populations that include primarily non-pregnant adults. These plans are the two HIV/AIDS Specialty plans (Positive Health Care and Clear Health Alliance), the Serious Mental Illness Plan (Magellan), and the Specialty Plan for Dual Eligibles with Chronic Conditions (Freedom). Due to the populations served by these plans, one or both of the mandatory PIP topics are not feasible for the plans due to the limited amount of enrollees meeting the eligibility criteria for the measures/areas targeted for improvement.

The State is not requesting any changes to the waiver authorities or expenditure authorities authorized October 15, 2015. The State is requesting to amend Special Term and Conditions #66, #108, and #87 of the MMA Waiver. The current approved STCs of the MMA waiver can be found at the link provided on page 3 of this document.

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 MMA plan from a list of nationally accredited MMA 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 outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.

- Improving program performance, particularly improved scores on nationally recognized quality measures (such as Health Plan Employer Data and Information Set (HEDIS) scores), through expanding key components of the Florida Medicaid MMA 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 Florida Medicaid participants in MMA 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 Florida Medicaid services to capitated, risk-adjusted payment systems. Strict financial oversight requirements are established for MMA plans to improve fiscal integrity.

2. Amendment Summary and Objective:

This amendment is requested to:

- Amend the waiver to allow the Agency for Health Care Administration (Agency) flexibility to contract with 1-3 vendors under the hemophilia program.
- Amend the waiver to include payment for nursing facility services in MMA capitation rates for recipients under the age of 18 years.
- Amend the waiver to allow flexibility for specialty plans to conduct Performance Improvement Projects (PIPs) on other topics that have more impact on their enrollees, with Agency approval.

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 Centers for Medicare and

Medicaid Cervices (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 was located in section (s.) 409.91211, Florida Statues (F.S.), and sunset October 1, 2014.

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

3. MMA Waiver Amendment (2014): On June 14, 2013, the State received CMS approval to amend the waiver to terminate the Florida Medicaid Reform program and implement the MMA program as approved by 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 Web site at the following link:

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

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 CMS on July 31, 2014. The effective dates of the waiver renewal period are July 31, 2014 through June 30, 2017.

5. MMA Waiver Amendment (2015): On October 15, 2015, the State received approval to (1) allow Medicaid-eligible children receiving Prescribed Pediatric Extended Care (PPEC) services and beneficiaries residing in group home facilities licensed under s. 393.067 F.S. to voluntarily enroll in managed care through the MMA Program, (2) allow changes to managed care enrollment to auto-assign individuals into managed care during a plan choice period immediately after eligibility determination and to allow changes to the auto-assignment criteria, and (3) to extend the Low Income Pool (LIP) through the remainder of the demonstration period ending June 30, 2017.

E. Waiver Amendment Requirements

The State is submitting this MMA Waiver amendment to 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 requirements for the public notice document.

Public Notice Document: The State posted the "Public Notice" document to solicit public input 30 days prior to submission of the amendment request to CMS. The state does not need to comply with the state public notice and comment process outlined in 42 CFR §431.408 until such time that CMS issues policy guidance to the contrary. However CMS encourages the state to comply with state public notice and comment process outlined in 42 CFR §431.408 in the event it seeks to amend the demonstration that modifies benefits, cost-sharing, eligibility, or delivery system changes. This public notice document will 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 III 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 the 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[1] located in Florida through written correspondence, to solicit input on the amendment request. Appendix A of this document provides the correspondence sent on January 12, 2016 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 held to solicit input on the amendment request.

- Published public notices for the two public meetings in the Florida Administrative Register (FAR) in compliance with Chapter 120, Florida Statutes (F.S.).
- Emailed 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.
- Posted on the Agency's home Web page 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 the 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/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_amend_waiver_2016-01.shtml

C. Florida Medicaid Advisory Meetings

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

- Public meeting was held in Tallahassee, FL on January 19, 2016
- Public meeting was held in Tampa, FL on January 21, 2016.

[1] 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) SSA. The purpose of the MCAC is to provide input on a variety of Florida Medicaid program issues, and to make recommendations to the Agency on Florida 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 Florida Medicaid recipients; and representatives of state agencies involved with the Florida 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 January 12, 2016, inviting all interested parties to the two public meetings listed in the table below. Individuals who were unable to attend the meeting in person could participate via conference call by using the toll-free number provided in the FAR notice. During the meetings, the Agency provided an overview of the MMA Waiver and description of the amendment request and allow 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
Tallahassee Agency for Health Care Administration 2727 Mahan Drive Building 3 Conference Room A Tallahassee, FL 32308 Conference Line: 1-888-670-3525 Participant Code: 371 527 4100#	January 19, 2016	2:00 p.m. – 4:00 p.m.
Tampa Agency for Health Care Administration, 6800 North Dale Mabry Highway, Main Training Room, Tampa, FL 33614 Conference Line: 1-877-299-4502 Participant Code: 639 773 84#	January 21, 2016	1:00 p.m. – 2:30 p.m.

Pursuant to the provisions of the Americans with Disabilities Act, any person that required special accommodations to participate in this workshop/meeting was asked to advise the

agency at least 7 days before the workshop/meeting by contacting Nicholas Warner at (850) 412-4033 or by email at Nicholas.Warner@ahca.myflorida.com.
If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1 (800) 955-8771 (TDD) or 1 (800) 955-8770 (Voice).

E. Public Notice Document Made Available to the Public

The Agency posted on its Web site (link provided on page 5) beginning January 12, 2016 through February 11, 2016, the public notice document as well as the dates, times and locations of the two public meetings.

F. Submission of Written Comments

The Agency 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

G. Summary of Public Comments

The following summarizes the public comments received during the 30-day comment period for the waiver amendment request that began January 12, 2016 and ended February 11, 2016.

Summary of Comments

- The Agency was asked to explain why the state is limiting the hemophilia program to no more than three vendors.
- The Agency was asked to explain how the changes in this amendment might impact the receipt of PPEC services, if any.
- The public wanted to know if the information discussed during the meeting was available on the Agency's Web site.
- The Agency was asked to explain whether CVS Caremark and Coram, the companies that currently provide services under the hemophilia program, are still considered two companies since Coram is now owned by CVS Caremark.
- It was recommended that the Agency develop standards to assess managed care plans that serve individuals with disabilities.

- It was recommended that the Agency consider use of a coordination of care model for the hemophilia program.

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 CMS.

A. Eligibility

1. Eligibility for Medicaid: The Florida Department of Children and Families is the administering agency responsible for processing Florida Medicaid applications and determining Florida 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 Florida 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 MMA plan or as a condition of receipt of Florida Medicaid benefits. Voluntary participants are exempt from mandatory enrollment, but have elected to enroll in a MMA plan to receive Florida 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 Population 2	No more than 206% of the Federal Poverty Level (FPL).	Title XIX	TANF & related grp
Children 1-5 Population 2	No more than 140% of the FPL.	Title XIX	TANF & related grp
Children 6-18 Population 2	No more than 133% of the FPL.	Title XIX	TANF & related grp
Blind/Disabled Children Population 1	Children eligible under SSI, or deemed to be receiving SSI.	Title XIX	Aged/Disabled

Table 2 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 Population 2	Who receive a state Foster Care or adoption subsidy, not under title IV-E.	Title XIX	TANF & related grp
Individuals eligible under a hospice-related eligibility group Population 1	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special income level group specified 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 enrollee 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 enrollee category in paragraph (c).	Title XIX	Aged/Disabled

b. Medicare-Medicaid Eligible Enrollees - Individuals fully eligible for both Medicare and Medicaid are required to participate in the MMA program for covered Florida 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 enrollees in an MMA plan:

   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);

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

   v. Children receiving services in a prescribed pediatric extended care (PPEC) facility; and,

   vi. Medicaid-eligible recipients residing in group home facilities licensed under section(s) 393.067 F.S.

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

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

   ii. Family planning waiver eligibles;

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

   iv. 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.

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 their application for Medicaid, individuals who would be mandated to enroll in managed care under MMA must receive information about managed care plan choices in their area. They must be informed of their options in selecting an authorized managed care plan. Individuals must be provided the opportunity to meet or speak with a choice counselor to obtain additional information in making a choice, and to indicate a plan choice selection if they are prepared to do so. Eligible individuals will be enrolled in a managed care plan upon eligibility determination. If the individual has not selected a plan at the time of the approval of eligibility, the state may auto-assign the individual into a managed care plan. Individuals who have been auto- assigned at enrollment will receive both their managed care plan assignment and information about choice of plans in their area. Such individuals then may actively select a plan during a 120-day change/disenrollment-period without cause post-enrollment. All individuals will be provided with information regarding their rights to change plans.

Once the plan selection is registered and takes effect, the plan must communicate to the enrollee, in accordance with 42 CFR 438.10, the benefits covered under the plan, including dental benefits, and how to access those benefits.

In accordance with STCs 2 and 3, the state must ensure that the enrollment and other managed care practices are brought into compliance with future final CMS Medicaid managed care regulations within the timeframe to be specified in that final rule (see as reference, proposed rule at 80 FR 104, June 1, 2015).

2. Auto-Enrollment Criteria. Each enrollee must have an opportunity to select a managed care plan before or upon being determined eligible for Medicaid. Individuals must be provided information to encourage an active selection electronically or in print.

Enrollees who fail to choose a plan by the time their eligibility is determined will be auto-assigned to a managed care plan. At a minimum, the state must use the criteria listed below when assigning an enrollee to a managed care plan. When more than one managed care plan meets the assignment criteria, the state will make enrollee assignments consecutively by family unit. The criteria include but are not limited to:

a. Whether the plan has sufficient provider network capacity, including dental network capacity, to meet the needs of the enrollee;

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.

3. Auto Enrollment for Special Populations. For an enrollee who is also a recipient of Supplemental Security Income (SSI), prior to assigning the SSI beneficiary to a managed care

plan, the state must determine whether the SSI beneficiary has an ongoing relationship with a provider or managed care plan; and if so, the state must assign the SSI recipient to that managed care plan whenever feasible. Those SSI recipients who do not have such a provider relationship must be assigned to a managed care plan using the assignment criteria previously outlined.

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

a. To promote alignment between Medicaid and Medicare, each beneficiary who is enrolled with a Medicare Advantage Organization, must first be assigned to any MMA plan in the beneficiary's region that is operated by the same parent organization as the beneficiary's Medicare Advantage Organization. If there is no match of parent organization or appropriate plan within the organization, then the beneficiary should be assigned as in subparagraphs 22(a) - (c) 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 120 days after the child's birth.

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

4. Lock-In/Disenrollment. Once a mandatory enrollee has selected or been assigned an MMA plan, the enrollee shall be enrolled for a total of 12 months, until the next open enrollment period, unless the individual is determined ineligible for Medicaid. The 12 month period includes a 120-day period upon initial eligibility or re-eligibility determination to change or voluntarily disenroll from a plan without cause and select another plan. If an individual chooses to remain in a plan past 120 days, the individual will be permitted no further changes in enrollment until the next open enrollment period, except for cause. Good cause reasons for disenrollment from a plan are defined in Rule 59-G-8.600, Florida Administrative Code. Voluntary enrollees may disenroll from the plan at any time.

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

5. Re-enrollment. In instances of a temporary loss of Medicaid eligibility, which the state is defining as 6 months or less, the state will re-enroll demonstration enrollees in the same capitated managed care plan or FFS PSN they were enrolled in prior to the temporary loss of eligibility unless enrollment into the entity has been suspended. The individual will have the same change/disenrollment period without cause as upon initial enrollment.

C. Information and Choice

1. Enrollee Choice: The State assures CMS that it will comply with section 1932(a)(3) and 42 CFR 438.52, relating to choice since at least two options will be available in all 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 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 Florida 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**	**Molina**	**Florida True Health d/b/a/**	**SFCCN**	**Simply**	**Staywell**	**Sunshine**	**United**
Adult dental services (Expanded)	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
Adult vision services (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Art therapy	Y			Y	Y				Y	Y	
Equine therapy									Y		
Home health care for non-pregnant adults (Expanded)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Influenza vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Medically related lodging & food		Y		Y	Y	Y		Y	Y	Y	
Newborn circumcisions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nutritional counseling	Y	Y	Y	Y	Y	Y		Y	Y	Y	
Outpatient hospital services (Expanded)	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
Pet therapy				Y	Y				Y		
Physician home visits	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Pneumonia vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Post-discharge meals	Y	Y	Y	Y	Y			Y	Y	Y	Y
Prenatal/Perinatal visits (Expanded)	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
Shingles vaccine	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

Table 4 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		

Table 4 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)**
Equine therapy						
Home and Community-Based Services		Y			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
Nutritional counseling		Y		Y	Y	Y
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	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 MMA plan.						

3. Benefit Packages: In addition to the expanded benefits available under the MMA program that are listed in Tables 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 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**

Table 5 MMA Plan Services	
(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**
(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 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

Table 6 Cost Sharing	
Services	**Co-payment / Co-insurance**
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 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 MMA 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
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 MMA Plans	
Plan Type	**Plan Name**
Standard Plans	**Better Health** **Florida True Health, d/b/a/** **Prestige Health Choice** **Simply** **Staywell** **South Florida Community Care Network**
Specialty Plans Plans contracted to provide services to a targeted population	**Clear Health Alliance** **Freedom Health** **Magellan Complete Care** **Positive Health Care** **Children's Medical Services Plan**
Comprehensive Plan Plans also contracted to provide LTC services under the 1915(b)(c) Long-term Care Waiver.	**Amerigroup Florida** **Coventry** **Humana Medical Plan** **Molina** **United Healthcare**

Comprehensive & Specialty Plan 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
Molina Healthcare of Florida	X			X		X	X	X	X		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 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 amendment request.

From Date of Service - SFY	Age Group	Unduplicated Recipient Count	Sum Of Reimbursed Amount
2015	Age 0 to 17	161	$21,341,594.36
2015	Age 18 to 20	22	$2,700,676.10
			$24,042,270.46

Budget Neutrality: Currently, MMA plans are not capitated for providing nursing facility services to children under 18, and this service is reimbursed outside of managed care on a fee-for-service basis. Requiring MMA plans to provide this service for children under 18 years of age eliminates a payment carve out and ensures that MMA plans are accountable for their care. This population is not expected to increase or decrease the annual MMA 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.

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 3 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 enrollees (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 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) · Hemoglobin A1c (HbA1c) testing · HbA1c poor control · HbA1c control (<8%) · Eye exam (retinal) performed · LDL-C screening · LDL-C control (<100 mg/dL) · 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 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 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 3 of this document. The Agency is working with 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 MMA plans are not responsible for the pharmaceutical services and products provided to MMA enrollees through the Comprehensive Hemophilia Disease Management Program (CHDMP); therefore, adding an additional Vendor would not impact the MMA program or evaluation of the MMA program. MMA plans are responsible for enrollee coordination of care with the approved Agency hemophilia Vendors. Coordination of care of all enrollees (including those accessing pharmaceutical services and products provided to MMA enrollees through the CHDMP) will be assessed through quality of care analyses which will assess overall ratings variables related to satisfaction with health care, health plan, personal doctor, specialists, getting needed care, ease in getting care, and getting care quickly.

The evaluation plan currently includes an analysis of the cost effectiveness of the MMA program. The analysis includes a comparison of costs pre and post- MMA implementation by eligibility group. The cost of the Nursing Facility service is included in the post MMA costs. Modifying the payment from outside to capitation payment to within the capitation payment will not require a change to the methodology of the analysis or an additional analysis.

The current evaluation design utilizes a review of the PIPs to assess strategies MMA and specialty MMA plans use to improve quality of care as well as to identify which of the strategies are most effective in improving quality of care and why. Amending the language to ensure that the PIPs are relevant to the populations served by the Specialty plan will not impact the evaluation of the MMA program.

VII. Waiver and Expenditure Authorities

The State is not requesting any changes to the waiver authorities or expenditure authorities authorized October 15, 2015. The State is requesting to amend Special Term and Condition #66, #108, and #87 of the MMA Waiver. The current approved 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 CMS October 15, 2015.

Appendix A
Letters to the Miccosukee Tribe and the Seminole Tribe

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 12, 2016

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

Dear Ms. Osceola:

This letter is being sent to notify the Miccosukee Tribe of Florida 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 seek to amend the language related to the Hemophilia Program to allow for up to three vendors in order to provide the State the flexibility to contract with 1-3 vendors, amend the waiver to include payment in MMA capitation rates for nursing facility services for recipients under the age of 18 years, and amend the waiver to allow flexibility for Specialty Plans that do not have sufficient numbers of eligible enrollees for the mandatory Performance Improvement Projects (PIPs) to conduct PIPs on other topics that have more impact on their enrollees, with the Agency for Health Care Administration's (Agency) approval.

A full description of the proposed amendment is located on the Agency website at the following link:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_amend_waiver_2016-01.shtml

The 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 be held January 12, 2016 through February 11, 2016.The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendment from the public. The meetings will be held in:

- Tallahassee, Florida on January 19, 2016, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Drive Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1-888-670-3525, participant passcode: 3715274100#.
- Tampa, Florida on January 21, 2016, 1:00 p.m. – 2:30 p.m. at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Main Training Room, Tampa, FL 33614. To participate by phone, please call 1-877-299-4502 and enter the participant passcode: 639 773 84#.

If you have any questions about this amendment or would like to hold a call please contact Nicholas Warner of my staff via email at Nicholas.Warner@ahca.myflorida.com or by phone at (850) 412-4031.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lm

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 12, 2016

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 seek to amend the language related to the Hemophilia Program to allow for up to three vendors in order to provide the State the flexibility to contract with 1-3 vendors, amend the waiver to include payment in MMA capitation rates for nursing facility services for recipients under the age of 18 years, and amend the waiver to allow flexibility for Specialty Plans that do not have sufficient numbers of eligible enrollees for the mandatory Performance Improvement Projects (PIPs) to conduct PIPs on other topics that have more impact on their enrollees, with the Agency for Health Care Administration's (Agency) approval.

A full description of the proposed amendment is located on the Agency website at the following link:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_amend_waiver_2016-01.shtml

The 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 be held January 12, 2016 through February 11, 2016. The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendment from the public. The meetings will be held in:

- Tallahassee, Florida on January 19, 2016, 2:00 p.m. – 4:00 p.m. at the Agency for Health Care Administration, 2727 Mahan Drive Building 3, Conference Room A, Tallahassee, FL 32308. To participate by phone, please call 1-888-670-3525, participant passcode: 3715274100#.
- Tampa, Florida on January 21, 2016, 1:00 p.m. – 2:30 p.m. at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Main Training Room, Tampa, FL 33614. To participate by phone, please call 1-877-299-4502 and enter the participant passcode: 639 773 84#.

If you have any questions about this amendment or would like to hold a call please contact Nicholas Warner of my staff via email at Nicholas.Warner@ahca.myflorida.com or by phone at (850) 412-4031.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/lm

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). The state acknowledges that it has not asked for, nor has it received, a waiver to Section 1902(a)(2). These waivers are effective beginning July 31, 2014, through June 30, 2017.

Title XIX Waivers

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

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

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

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

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

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

Appendix C
Waiver 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). The authorities also promote the objectives of title XIX in the following ways:

- Expenditure authorities 1 and 3 promote the objectives of title XIX by improving health outcomes for Medicaid and other low-income populations in the state; and
- Expenditure authority 2 promotes the objectives of title XIX by increasing access to, stabilizing, and strengthening providers to serve uninsured, low-income populations in the state

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

2. For demonstration year 10, through June 30, 2016, and demonstration year 11, July1, 2016- June 30, 2017, expenditures made by Florida for uncompensated care costs incurred by providers for health care services for the uninsured and or underinsured, subject to the restrictions placed on the Low Income Pool, as defined in the STCs.

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

This page intentionally left blank.

State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

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

Mission Statement
Better Healthcare for All Floridians.