Florida Medicaid
Managed Medical Assistance Waiver

1115 Research and Demonstration Waiver
#11-W-00206/4

Amendment Request
9/1/2017

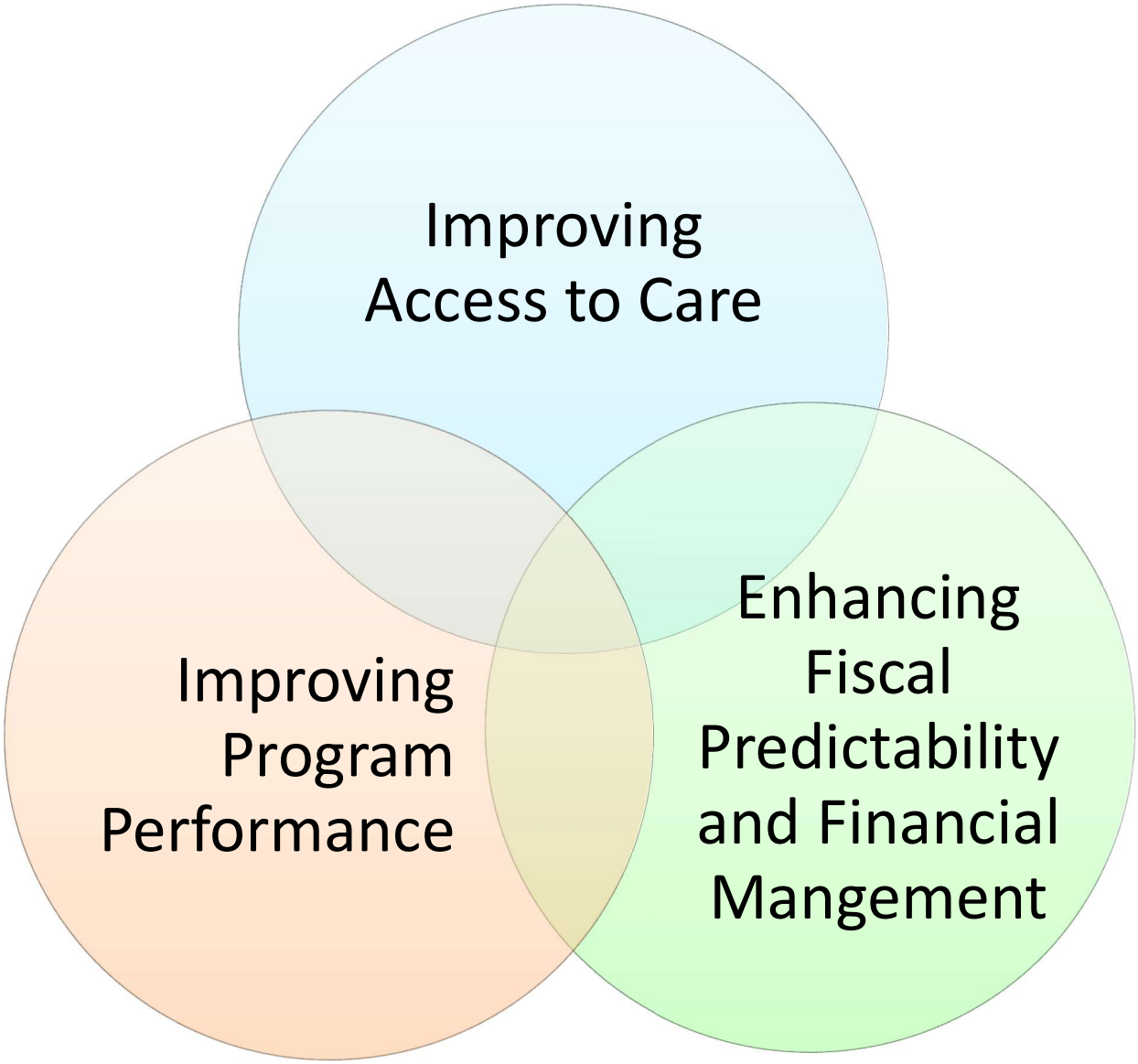
Agency for Health Care Administration

This page intentionally left blank.

Table of Contents

Introduction

The Managed Medical Assistance (MMA) program improves health outcomes for Florida Medicaid recipients while maintaining fiscal responsibility. This is achieved through care coordination, patient engagement in their own health care, enhancing fiscal predictability and financial management, improving access to coordinated care and improving overall program performance.



Purpose, Goals, and Objectives

Statement of Purpose

The Agency for Health Care Administration (Agency) is seeking federal authority to amend Florida Medicaid's 1115 MMA Waiver (Project Number 11-W-00206/4) to achieve the following effective January 1, 2018:

- Establish financial and non-financial eligibility criteria (specified in section 409.904, Florida Statues) in the 1115 MMA Waiver that enables individuals who are diagnosed with Acquired Immune Deficiency Syndrome (AIDS) to obtain and maintain Medicaid coverage without the need for enrollment in the 1915(c) Project AIDS Care (PAC) Waiver. This population does not need home and community-based services (HCBS) but are at risk for institutionalization without access to necessary medical/acute care services (prescribed drugs, physician services, etc.). This change enables the population to maintain access to needed services and will result in no loss of Medicaid coverage.

- Transition the federal authority to serve individuals enrolled in the 1115 MEDS-AD Waiver to the 1115 MMA Waiver. This is a technical change; the population will continue to have access to all Medicaid covered services.

There State is not proposing any programmatic or operational changes to the MMA program other than those specified in this amendment request. For information about the MMA program, visit the Agency's Web site at: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml.

Effect on Recipients

Individuals enrolled in the MEDS-AD Waiver, and those diagnosed with AIDS will continue to be eligible for Florida Medicaid and receive their acute care services in the same manner they do now unless they choose to change MMA plan or their service provider is no longer available.

Goals and Objectives

The goals and objectives of this waiver amendment are to ensure continued Florida Medicaid coverage and access to needed health care services for vulnerable populations while also achieving administrative efficiencies by consolidating the authority for the MEDS-AD waiver population and the PAC waiver population under the authority of Florida's 1115 MMA Research and Demonstration Waiver.

1115 MEDS-AD Research and Demonstration Waiver

Historical Overview

In 2005, State legislation (Chapter 2005-60, Laws of Florida) directed the Agency to discontinue coverage of certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level (an optional Medicaid eligibility group) under the Medicaid state plan. However, concerned that this population was at risk for costly adverse events, the Florida Legislature directed the Agency to seek a federal waiver to continue to provide benefits to a subset of the individuals in this eligibility group.

The current Florida MEDS-AD Research and Demonstration Waiver began operations in January 2006 and provides Florida Medicaid coverage for aged or disabled residents of the State of Florida with incomes at or below 88 percent of the federal poverty level and assets at or below $5,000 for an individual or $6,000 for a couple. This waiver was designed to delay or prevent the need for institutionalization of these vulnerable individuals by maintaining their level of care in the community longer through the provision of:

- Access to health care services

- High-intensity pharmacy case management services for non-institutionalized individuals and individuals not enrolled in managed care (also referred to as the Medication Therapy Management (MTM) program)

The continued coverage is designed to avoid costs of preventable hospitalizations or institutional placement that would otherwise occur had these vulnerable individuals not had access to prescribed drugs and other medical services.

Medication Therapy Management Program

The MTM program provides high intensity pharmacy case management to individuals enrolled in the MEDS-AD waiver who are not; Medicare eligible, enrolled in an MMA plan, institutionalized, or in hospice care. The recipients who elect to participate in the MTM program engage in a comprehensive medication review with a pharmacist and receive a Patient Medication Action Plan at the conclusion of the review. The results of the comprehensive medication review, along with the Patient Medication Action Plan, are sent to the recipient's treating practitioner. Quarterly follow up calls are completed with the recipient and recommendations are communicated to the treating practitioner, as necessary. The goal of this process is to maximize opportunities for patient treatment adherence and facilitate use of evidence-based prescribing practices among treating practitioners.

There are currently approximately 50,000 recipients enrolled in the MEDS-AD Waiver. Approximately 91% are currently enrolled in, and receiving their services through, an MMA plan. The MMA plans are required to provide case management/care coordination services and programs that have similar objectives to the MTM program. To avoid duplication, only recipients who are receiving services through the fee-for-service delivery system (approximately 9% of the MEDS-AD population) are potentially eligible to participate in the MTM program. As a result, the total population that is eligible to participate in the MTM program is small and continues to diminish as more individuals elect to enroll in an MMA plan. To recruit the minimum number of MTM participants (100), the evaluation team historically has had to contact up to three times this number of individuals. Consequently, maintaining the

integrity of the MTM program has become increasingly difficult given the declining eligible population, reduced interest, and the attrition rate from the waiver whereby individuals participating in the MTM program transition to another Florida Medicaid eligibility group or program prior to completing the MTM program.

Transition Plan for the MEDS-AD Population

With this amendment, the State is seeking federal approval to transition the federal and expenditure authority to serve individuals enrolled in the 1115 MEDS-AD Waiver to the 1115 MMA Waiver. This is a technical amendment request – transitioning the authority to operate the demonstration from one 1115 waiver to another. The eligibility, enrollment, and benefit design elements that are currently approved in the 1115 MEDS-AD Waiver will not substantively change under the authority of the 1115 MMA Waiver.

Eligible Population

All applicable Florida Medicaid laws or regulations apply to eligibility, and coverage of the population described below, in accordance with the Florida Medicaid state plan. Eligibility under the demonstration is limited to the following individuals not otherwise eligible for Florida Medicaid:

Demonstration Eligible Groups	Qualifying Criteria
Aged or disabled individuals – Medicaid Only	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services
Aged or disabled individuals – Medicaid Institutional	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicaid-only eligibles receiving hospice, HCBS, or institutional care services
Aged or disabled individuals – Dual Eligibles	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicare Eligible • Receiving hospice, HCBS, or institutional care services

Benefits

Recipients enrolled in the demonstration receive all services offered through the state plan as well as the HCBS provided in the programs identified below in accordance with the specified authority:

- Program of All-Inclusive Care for the Elderly, section 1934 of the Social Security Act (SSA)

- Developmental Disabilities Individual Budgeting Waiver, section 1915(c), SSA

- Model Waiver, section 1915(c), SSA

- Long-term Care Waiver, section 1915(b)/(c), SSA

Availability of the home and community-based services is subject to any numeric limitation on enrollment in such programs, and the requirements that the individual meets the eligibility, and level of care criteria required to receive services through these programs.

Recipients enrolled in the demonstration will continue to receive medical/acute care services through an MMA plan, consistent with the mandatory, and voluntary participation requirements currently approved in the 1115 MMA Waiver. Recipients who do not enroll in an MMA plan will receive services through the Florida Medicaid fee-for-service delivery system.

MTM Program

The Agency will allow individuals who are currently participating in the MTM program as of July 1, 2017 to complete their term. The Agency will not enroll new participants after the current cohort of participants completes the program. Since the majority of MEDS-AD recipients are receiving services through the MMA program, and are already eligible to receive case management/care coordination through their MMA plan. The Agency believes that the goals and objectives of the MTM program are satisfied by the design and contractual requirements of the SMMC program. As such, the Agency is not requesting authority to continue the MTM program as a unique demonstration component under the 1115 MMA Waiver.

1915(c) Project AIDS Care Home and Community-Based Services Waiver

Program Overview

Florida's 1915(c) PAC HCBS Waiver operates statewide and was designed to promote, maintain, and optimize the health of persons living with AIDS through the provision of HCBS, in order to delay or prevent institutionalization.

The 2017 Florida Legislature amended section 409.904, Florida Statutes to allow individuals diagnosed with AIDS to obtain and maintain Florida Medicaid coverage without the need for enrollment in the PAC Waiver. In order to qualify, an individual must meet the criteria currently used for the PAC Waiver:

- Have an income at or below 222% of the federal poverty level (or 300% of the federal benefit rate), and

- Meet hospital level of care, as determined by the Department of Elder Affairs, Comprehensive Assessment and Review for Long-term Care Services (CARES)

With the advances that have been made over the last decade in the treatment of HIV and AIDS, the majority of individuals currently enrolled in the PAC Waiver (approximately 5,300) do not use or need the HCBS offered through the waiver; they are currently only receiving case management services through the PAC Waiver. With this amendment, the State is seeking to

establish financial and non-financial eligibility criteria (specified in section 409.904, Florida Statues) under the authority of Florida's 1115 MMA Waiver to enable individuals who are diagnosed with AIDS to obtain and maintain Florida Medicaid coverage without the need for enrollment in the 1915(c) PAC Waiver. This change only applies to individuals who do not need HCBS but are at risk for institutionalization without access to necessary medical/acute care services (prescribed drugs, physician services, etc.). This change enables the population to maintain access to needed services.

In addition, approximately 1,000 individuals only access massage therapy and/or specialized medical equipment and supply services through the PAC Waiver in addition to case management services. The State will maintain these individual's eligibility for Florida Medicaid as specified above. These individuals will maintain access to these services through the State Plan, and through expanded benefits and flexibilities afforded through the MMA program.

PAC Service	State Plan Service
Restorative Massage: Restorative massage services are limited to recipients with peripheral neuropathy or severe neuromuscular pain and lymphedema. This service includes evaluation and treatment. Included is the examination of six physiological factors which create or intensify pain in the body: ischemia, trigger points, nerve entrapment or compression, postural distortion, nutritional and emotional wellbeing. The purpose of this service is to enhance the function of the joints, muscles and biomechanics (movement).	**Physical Therapy Services:** Physical therapy services develop, maintain, improve, or restore neuro-muscular or sensory motor function to relieve pain, acquire a skill set, restore a skill set, or control postural deviations. **Chiropractic Services:** Chiropractic services focuses on the diagnosis and manipulative treatment of misalignments of the joints, especially those of the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs.
Specialized Medical Equipment and Supplies: Specialized medical equipment and supplies include devices, controls, or appliances specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items.	**Durable Medical Equipment (DME) and Medical Supplies:** The purpose of DME and medical supply services is to promote, maintain, or restore health and minimize the effects of illness, disability, or a disabling condition, including: • Equipment that can withstand repeated use, serves a medical purpose, and is appropriate for use in the recipient's home.

	• Medical or surgical items that are consumable, expendable, disposable, or non-durable and appropriate for use in the recipient's home. • Devices or appliances that support or correct a weak or deformed body part, or restrict or eliminate motion in a diseased or injured body part. • Artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.

The remaining recipients in the PAC Waiver who have been receiving more than case management services and continue to need HCBS in order to live safely in the community will transition into the 1915(b)/(c) Long-term Care (LTC) Waiver for their HCBS needs. This will enable them to maintain their Medicaid eligibility and continued access to medical/acute care benefits; they will also continue to receive all HCBS through the LTC program. The LTC program offers a more robust benefit package than the PAC Waiver, including enhanced case management standards and expanded benefits. The Agency is pursuing separate federal authority for that transition through an amendment of the 1915(b)/(c) LTC Waiver, which will be submitted concurrently with the amendment request for the 1115 MMA Waiver.

Transition Plan for PAC Waiver Participants

Eligible Population

All applicable Florida Medicaid laws or regulations apply to eligibility and coverage of the population described below, in accordance with the Florida Medicaid state plan. Eligibility under the demonstration is limited to the following individuals not otherwise eligible for Florida Medicaid:

Demonstration Eligible Groups	Qualifying Criteria
MEG 4: AIDS	• Confirmed diagnoses of AIDS • Income at or below 222% FPL • Assets that do not exceed $2,000 (individual) or $3,000 (couple) • Meet hospital level of care, as determined by the Department of Elder Affairs, Comprehensive Assessment and Review for Long-term Care Services

The Florida Department of Children and Families' Office of Economic Self-Sufficiency will continue to determine Medicaid eligibility for this population. The Agency will work with DCF to implement all systems/operational modifications to facilitate this change and to ensure a seamless transition, such that there will be no gap or break in Florida Medicaid coverage as a

result of this change. At the time of transition, all affected recipient's aid categories will be updated in DCF's and the Agency's systems to reflect this new eligibility group.

In the future, individuals diagnosed with AIDS (who were not part of this transition) who meet the eligibility requirements specified above, may submit a Florida Medicaid application to DCF for processing.

Benefits

Recipients enrolled in the demonstration receive all services offered through the Florida Medicaid state plan. There will be no loss in services that are currently being utilized by the population.

- Recipients ages 21 years and older will continue to access all state plan services that are currently covered for adults and will be eligible to receive medically necessary restorative massage and incontinence supplies not otherwise available to adult recipients.

- Recipients under the age of 21 years will continue to have access to all state plan services and Early and Periodic Screening, Diagnosis and Treatment benefits that are currently covered for children.

Most recipients enrolled in the PAC Waiver currently receive their medical, dental, behavioral health, and prescribed drug services from an MMA plan. There will be no change in how these individuals receive MMA services, unless they choose to change plans. There will be no change for recipients who are not enrolled in an MMA plan, and instead receive the aforementioned services through a Medicare Advantage Fully Liable Dual Eligible Special Needs Plan (D-SNP). This change will not affect how D-SNP enrollees receive their Medicare or Medicaid benefits.

Evaluation

The State determined adding additional goals or objectives to the hypotheses and the parameters of the current evaluation design would not be necessary. The current evaluation design already includes these populations since the MEDS-AD population and individuals with AIDS currently receive services through the MMA program.

Expenditure Authority

See Attachment I for the State's current approved Waiver and Expenditure Authorities. The State is seeking expenditure authority to provide Florida Medicaid eligibility to the following populations:

MEDS-AD Demonstration Only Population: Expenditures for services provided to the below MEDS-AD population groups.

MEDS-AD Population 1. Expenditures for services provided to elderly or disabled individuals who are not otherwise eligible for Florida Medicaid and who:

a. Have income less than or equal to 88 percent of the federal poverty level;

b. Have assets up to $5,000 for an individual or $6,000 for a couple; and

c. Are not receiving hospice, home and community-based services, or institutional care services.

MEDS-AD Population 2. Expenditures for services provided to elderly or disabled individuals who are not otherwise eligible for Florida Medicaid and who:

a. Have income less than or equal to 88 percent of the federal poverty level;

b. Have assets up to $5,000 for an individual or $6,000 for a couple; and

c. Are receiving hospice, home and community-based services, or institutional care services.

MEDS-AD Population 3. Expenditures for services provided to elderly or disabled individuals who are not otherwise eligible for Florida Medicaid and who:

a. Are eligible for Medicare;

b. Have income less than or equal to 88 percent of the federal poverty level;

c. Have assets up to $5,000 for an individual or $6,000 for a couple; and

d. Are receiving hospice, home and community-based services, or institutional care services.

Individuals with AIDS Population: Expenditures for services provided to individuals diagnosed with AIDS who are at risk of hospitalization as determined by the State or its designee, and whose income is at or below 300 percent of the Federal Benefit Rate (222% Federal Poverty Level).

Budget Neutrality Compliance

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.

The State has attached the revised budget neutrality templates used to determine the financial impact for transitioning the authority for the 1115 MEDS AD Waiver and 1915(c) PAC Waiver populations under the authority of the 1115 MMA Waiver.

Individuals diagnosed with AIDS are categorized as "SSI". The approved budget neutrality for the MMA Waiver accounts for expenditures related to this group in the MEG 1 population. There is not expected to be an increase or decrease in the annual MMA aggregate expenditures since this population is already accounted for. The Medicaid eligibility group (MEG) 1 and MEG 2 Per Member Per month (PMPM) cost should remain unchanged for the MMA Waiver, with waiver (WW) and without waiver (WOW).

The State has added a new MEG to the MMA Waiver budget neutrality to capture the expenditures associated with the MEDS-AD demonstration Group. The State expects the addition of the "MEG 4 - MEDS-AD demonstration group" will increase aggregate expenditures. The MMA historical expenditures and member months was updated to include the costs associated with the new MEG as well as revisions and updates to the WW and WOW calculations. The net summary effect was a $7.8 million increase in the waiver's grand total variance.

The Florida MEDS-AD Demonstration was approved in November 2005 and its expenditures were subject to the Title XIX Budget Neutrality Expenditure Limit. During the extension negotiations for the MEDS-AD Waiver Demonstration Year (DY) 6-8, the State and CMS mutually agreed to limit the future cumulative ceiling at the DY 5 target level. The State continues to demonstrate budget neutrality under this ceiling cap.

Demonstration Year	Cumulative Target		Definition Percentage
	Annual	Quarterly	
DY 1	$2,030,843,575	$507,710,894	8 percent
DY 2	$3,873,646,079	$460,700,626	3 percent
DY 3	$5,697,644,476	$455,999,599	1 percent
DY 4	$7,559,251,086	$465,401,653	0.5 percent
DY 5	$9,402,053,590	$460,700,626	0.0 percent

The table, located in Attachment II, provides cumulative expenditures and case months for each demonstration year.

Public Notice Process

Public Notice Process

The State conducted a public comment period from August 1, 2017 – August 30, 2017 to solicit input on the waiver amendment request.

The State notified stakeholders of the public comment period using the following methods:

- Published public notice on July 31, 2017 in the Florida Administrative Register (FAR) in compliance with Chapter 120, Florida Statutes
- Emailed individuals and organizations on its interested stakeholders list
- Posted a provider alert on the Agency's Web site

Public Notice Materials

The State posted the dates, times, and locations of two public meetings, and a link to this public notice document on the Agency's Web site at: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/index.shtml

The State provided this link in the FAR notice and email to interested stakeholders.

Consultation with Indian Health Programs

The State sent written correspondence to the Indian Health Programs located in Florida to solicit input on the waiver amendment request (Attachment IV). The State of Florida does not have any Urban Indian Organizations, but has two federally recognized tribes: the Seminole Tribe and Miccosukee Tribe.

Public Meetings

The State held two public meetings during the public comment period. Individuals unable to attend the meetings in person could participate via conference call by using the toll-free number provided. During the meetings, the State provided a brief overview of the 1115 MMA Waiver amendment request and allowed time for public comment.

MMA Amendment Public Meetings		
Location	**Date**	**Time**
Tallahassee Agency for Health Care Administration 2727 Mahan Drive, Building 3 Tallahassee, FL 32308 Conference Line: 1-877-309-2071 Participant Code: 798-884-808	August 9, 2017	11:00 am-12:00 pm
Tampa Agency for Health Care Administration 6800 N. Dale Mabry Highway, Suite 220 Main Training Conference Room Tampa, FL 33614 Conference Line: 1-877-309-2071 Participant Code: 536-371-224	August 18, 2017	1:00 p.m. - 3:00 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 seven days before the workshop/meeting by contacting Kimberly Quinn at (850) 412-4284 or by email at Kimberly.Quinn@ahca.myflorida.com.

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

Submitting Written Comments

Written comments on the waiver extension could be submitted via mail or email with the subject "1115 MMA Amendment – Waiver Consolidation" during the public comment period.

Mail: Agency for Health Care Administration
Bureau of Medicaid Policy
2727 Mahan Drive, MS #20
Tallahassee, Florida 32308

Email: FLMedicaidWaivers@ahca.myflorida.com

Summary of Public Comments

The following summarizes the public comments received during the 30-day comment period that began August 1, 2017 and ended August 30, 2017. The State considered all comments received in preparing the amendment request.

Project AIDS Care Waiver Transition

- The State received comments on whether recipients would have access to all of the services that they currently receive through the PAC waiver.

- The State received comments on case management in the MMA program and how communication with recipients would occur. Emphasis was placed on recipients in rural areas who may require face to face contact in place of telephonic contact from their case manager due to lack of consistent internet/phone access.

- The State received comments on whether the MMA plan case managers would receive training specifically for the HIV/AIDS population.

- The State received comments on the waitlist process and how it will operate post implementation.

- The State received comments on how the transition will operate for recipients enrolled in both Medicare and Medicaid and how will function.

- The State received comments on how individuals would apply for and obtain Medicaid services post implementation.

- The State received comments on the confidentiality requirements related to recipient records and inquired if it would remain the same.

- The State received comments on how the level of care determination process would function and what forms would be required to determine level of care.

- The State received comments on the availability of HIV/AIDS specialty plans within the State.

- The State received comments on expanded benefits available under the MMA HIV/AIDS specialty plans.

MEDS-AD Waiver Transition

The State did not receive any comments specific to the 1115 MEDS-AD Waiver transition.

Attachment I
Waiver and Expenditure Authority

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 (STC). The state has acknowledged 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.

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, July 1, 2016 through 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.

Attachment II
Budget Neutrality Tables

MEG 4 Cumulative Statistics

DY 01	Actual CM	Total	PCCM
Meg 4	422,862	584,535,236	$1,382.33
WOW	422,862	2,952,244,827	$6,981.58
Difference		2,367,709,591	
% Of WOW			19.80%
DY 02	**Actual CM**	**Total**	**PCCM**
Meg 4	291,688	374,769,277	$1,284.83
WOW	291,688	1,833,400,451	$6,285.48
Difference		1,458,631,174	
% Of WOW			20.44%
DY 03	**Actual CM**	**Total**	**PCCM**
Meg 4	311,248	405,982,888	$1,304.37
WOW	311,248	1,842,802,504	$5,920.69
Difference		1,436,819,616	
% Of WOW			22.03%
DY 04	**Actual CM**	**Total**	**PCCM**
Meg 4	370,314	536,897,998	$1,449.85
WOW	370,314	1,852,204,557	$5,001.71
Difference		1,315,306,559	
% Of WOW			28.99%
DY 05	**Actual CM**	**Total**	**PCCM**
Meg 4	450,710	583,911,712	$1,295.54
WOW	450,710	1,842,802,504	$4,088.67
Difference		1,258,890,792	
% Of WOW			31.69%
DY 06	**Actual CM**	**Total**	**PCCM**
Meg 4	506,112	669,068,962	$1,321.98
WOW	506,112	1,842,802,504	$3,641.10
Difference		1,173,733,542	
% Of WOW			36.31%
DY 07	**Actual CM**	**Total**	**PCCM**
Meg 4	495,533	635,756,114	$1,282.97
WOW	495,533	1,842,802,504	$3,718.83
Difference		1,207,046,390	
% Of WOW			34.50%

DY 08	Actual CM	Total	PCCM
Meg 4	490,260	650,969,064	$1,327.80
WOW	490,260	1,842,802,504	$3,758.83
Difference		1,191,833,440	
% Of WOW			35.32%
DY 09	**Actual CM**	**Total**	**PCCM**
Meg 4	436,384	520,030,966	$1,191.68
WOW	436,384	1,842,802,504	$4,222.89
Difference		1,322,771,538	
% Of WOW			28.22%
DY 10	**Actual CM**	**Total**	**PCCM**
Meg 4	542,642	544,934,453	$1,004.22
WOW	542,642	1,842,802,504	$3,395.98
Difference		1,297,868,051	
% Of WOW			29.57%
DY 11	**Actual CM**	**Total**	**PCCM**
Meg 4	438,120	663,688,386	$1,514.86
WOW	438,120	1,842,802,504	$4,206.16
Difference		1,179,114,118	
% Of WOW			36.02%

Attachment III
Standard Financial Management Questions

1. The following questions are being asked and should be answered in relation to all payments made to all providers under the section 1115 demonstration under review. Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan.

    a. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the federal and non-federal share (NFS) or is any portion of any payment returned to the state, local governmental entity, or any other intermediary organization?

    Response: Providers retain 100 percent of all payments made relating to this program.

    b. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the state (i.e., general fund, medical services account, etc.).

    Response: If an error occurs and payments are returned to the State, the State will track and report appropriately. The federal share is calculated and returned to Federal CMS by making adjustments on the quarterly CMS 64 report.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

    a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

    Response: The state share of payments for this program is appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund (HCTF), and the Provider Medical Assistance Trust Fund (PMATF).

    b. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer (IGT) agreements, certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide the NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please also indicate if any

managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans participate in IGT or CPE arrangements.

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

c. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

Response: The state share of payments for this program is appropriated by the Florida Legislature from the State's general revenue, the Health Care Trust Fund (HCTF), and the Provider Medical Assistance Trust Fund (PMATF).

d. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Response: There are no intergovernmental transfers or certified public expenditures directly related to the payments for this program.

e. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds is in accordance with 42 CFR 433.51(b).

Response: There are no certified public expenditures directly related to the payments for this program.

f. For any payment funded by CPEs or IGTs, please provide the following: (i) a complete list of the names of entities transferring or certifying funds;

(ii) the operational nature of the entity (state, county, city, other);

(iii) the total amounts transferred or certified by each entity;

(iv) clarify whether the certifying or transferring entity has general taxing authority; and

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response: There are no intergovernmental transfers or certified public expenditures directly related to the payments for this program.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for federal financial participation

to states for expenditures for services under an approved state Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

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

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (state owned or operated, non-state government owned or operated, and privately owned or operated).

   Response: The UPL demonstration reflecting SFY 2015-16 will be submitted electronically.

5. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

   a. If payments exceed the cost of services (as defined above), does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

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

6. In the case of risk-based MCOs, PIHPs, and PAHPs:

   a. Are there any payments to MCOs, PIHPs, PAHPs, or providers that are outside of the actuarial sound capitation rates in 42 CFR 438.4?

      Response: Yes, besides the capitation payments made to MCOs, Florida Medicaid also pays MCOs supplemental (kick) amounts for maternity costs and for certain Medicaid covered transplants, and a separate annual amount for the ACA Health Insurance Providers Fee (HIPF). The kick payments are developed by our actuaries and the HIPF methodology and amounts are reviewed by our actuaries.

   b. Are there any actual or potential payments which would be subject to 42 CFR 438.6(b), 438.6(c), 438.6(d), 438.60, or 438.74? (These payments could be for such things as managed care plan incentive arrangements, risk sharing mechanisms such as stop-loss limits, risk corridors, medical loss ratios with a remittance, or contractual requirements that direct the managed care plans on how to pay providers, or direct payments from the State to providers such as DSH hospitals, academic medical centers, or FQHCs.)

      Response: Yes, Florida Medicaid pays DSH hospitals, certain hospitals for Graduate Medicaid Education (GME), Medical School Faculty payments, and wrap payments to FQHCs.

c. If so, how do the arrangements in Item (b) comply with the requirements on payments in §438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74 of the managed care regulations?

Response: All payments are in compliance with the requirements on payments of the managed care regulations.

d. In situations, where MCOs, PIHPs, or PAHPs are not permitted to retain some or all of the recoveries of overpayments under the policies required in 42 CFR 438.608(d), does the state return the federal share of the recovery to CMS on the quarterly expenditure report?

Response: No, Florida Medicaid does not require MCOs to refund to the State any recoveries of overpayments to their network providers.

7. In the case of non-risk-based PIHPs, and PAHPs:

a. How do the arrangements comply with the upper payment limits specified in §447.362 limits on payments?

Response: Payments are limited to the Medicaid fee-for-service rate on the applicable Medicaid fee-for-service schedule.

b. If payments exceed the cost of services, does the state recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

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

Attachment IV
Tribal Notification

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

July 31, 2017

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

Dear Ms. Osceola:

The Agency for Health Care Administration (Agency) is announcing the start of a 30-day public notice and comment period. The Agency is seeking to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver and 1915(b)/(c) Long-term Care (LTC) Waiver to:

- Transition individuals enrolled in the 1915(c) Adults with Cystic Fibrosis (ACF) Waiver and the 1915(c) Traumatic Brain and Spinal Cord Injury (TBI/SCI) Waiver into the 1915(b)/(c) LTC Waiver in order for them to continue to receive home and community-based services (HCBS). This change will result in no loss of Medicaid coverage or services for these populations.
- Transition individuals enrolled in the 1915(c) Project AIDS Care (PAC) Waiver who are receiving HCBS and who meet nursing facility level of care into the 1915(b)/(c) LTC Waiver in order for them to continue to receive HCBS. This change will result in no loss of Medicaid coverage or services for the population.
- Establish financial and non-financial eligibility criteria (specified in section 409.904, Florida Statues) in the 1115 MMA Waiver that will enable individuals who are diagnosed with Acquired Immune Deficiency Syndrome (AIDS) to obtain and maintain Medicaid coverage without the need for enrollment in the 1915(c) PAC Waiver. This population does not need HCBS but are at risk for institutionalization without access to necessary medical/acute care services (prescribed drugs, physician services, etc.). This change enables the population to maintain access to needed services and will result in no loss of Medicaid coverage.
- Transition the federal authority to serve individuals enrolled in the 1115 MEDS-AD Waiver to the 1115 MMA Waiver. This is a technical change; the population will continue to have access to all Medicaid covered services.

The vast majority of these individuals are currently enrolled in an MMA plan for receipt of their medical, behavioral health, prescribed drugs, and dental services. The proposed changes will not affect how they receive these services or the plan in which they are enrolled.

Individuals who are transitioning to the 1915(b)/(c) LTC Waiver will have an opportunity to choose their LTC plan and will continue to have access to HCBS that are comparable to the services they are currently utilizing. In addition, the LTC program offers a more robust benefit package than the 1915(c) TBI/SCI, ACF, and PAC Waivers, including enhanced case management standards and expanded benefits. The LTC program also offers individuals an opportunity to receive care/services through a program with enhanced quality outcome measures.

The Agency is also seeking authority from the Centers for Medicare and Medicaid Services to end the 1915(c) TBI/SCI, ACF, and PAC Waivers, and the 1115 MEDS-AD Waiver once all transitions (described above) are complete.

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

The Agency is seeking federal approval to have all transitions completed by January 1, 2018.

The Agency will conduct a 30-day public comment period from August 1, 2017 through August 30, 2017. The Agency will consider all public comments received during the public notice period regarding the proposed amendments. You may view the full waiver amendment requests on the Agency's Web site at the following link: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/index.shtml.

The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendments. The meetings will be held in:

- Tallahassee, Florida on August 9, 2017 from 11:00 am – 12:00 pm at the Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Conference Room B, Tallahassee, FL 32308. To participate by phone, please call: 1 (877) 309-2071 and enter the participant passcode: 798-884-808. To participate by webinar, please visit: https://attendee.gotowebinar.com/register/8495210935345411.

- Tampa, Florida on August 11, 2017 from 1:00 – 2:00 pm at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Main Training Conference Room, Tampa, FL 33614. To participate by phone, please call: 1 (877) 309-2071 and enter the participant passcode: 536-371-224. To participate by webinar, please visit: https://attendee.gotowebinar.com/register/3884192334985328387.

When providing comments, please include "Proposed Amendment to 1115 MMA Waiver," "Proposed Amendment to 1115 MEDS-AD Waiver," "Proposed Amendment to 1915(b)/(c) Long-term Care Waiver," or "Proposed Amendment to 1915(c) Project AIDS Care Waiver" in the subject line as appropriate:

- Submit email comments to FLMedicaidWaivers@ahca.myflorida.com.
- Submit comments by mail to Bureau of Medicaid Policy, Agency for Health Care Administration, 2727 Mahan Drive, MS 20, Tallahassee, Florida 32308.

If you have any questions about the amendment request or would like to hold a call please contact Kimberly Quinn of my staff via email at Kimberly.Quinn@ahca.myflorida.com or by phone at (850) 412-4284.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

BK/kq

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

August 10, 2017

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

Dear Ms. Osceola:

The Agency for Health Care Administration sent a letter dated July 31, 2017 regarding proposed amendments to Florida's 1115 Managed Medical Assistance Waiver, 1115 MEDS-AD Waiver, 1915(c) Project AIDS Care Waiver, and 1915(b)/(c) Long-term Care Waiver. Please be advised the Tampa public meeting has been rescheduled as referenced below.

The public meeting is to solicit meaningful input on the proposed waiver amendments. The meeting will be held in Tampa, Florida on August 18, 2017 from 1:00 – 3:00 pm.

Location: The Agency for Health Care Administration
Main Training Conference Room
6800 N. Dale Mabry Highway, Suite 220
Tampa, FL 33614

To participate via telephone you may call: 1-877-309-2071
Participant Code: 536-371-224.

Participation via webinar: https://attendee.gotowebinar.com/register/3884192334985328387

If you have any questions please contact Kimberly Quinn of my staff via email at Kimberly.Quinn@ahca.myflorida.com or by phone at (850) 412-4284.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

BK/kq

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

July 31, 2017

Paul Isaacs, MD, CHFP, CHC
Executive Director, Health & Human Services
Seminole Tribe of Florida
6365 Taft Street, Suite 2004
Hollywood, FL 33024

Dear Dr. Isaacs:

The Agency for Health Care Administration (Agency) is announcing the start of a 30-day public notice and comment period. The Agency is seeking to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver and 1915(b)/(c) Long-term Care (LTC) Waiver to:

- Transition individuals enrolled in the 1915(c) Adults with Cystic Fibrosis (ACF) Waiver and the 1915(c) Traumatic Brain and Spinal Cord Injury (TBI/SCI) Waiver into the 1915(b)/(c) LTC Waiver in order for them to continue to receive home and community-based services (HCBS). This change will result in no loss of Medicaid coverage or services for these populations.
- Transition individuals enrolled in the 1915(c) Project AIDS Care (PAC) Waiver who are receiving HCBS and who meet nursing facility level of care into the 1915(b)/(c) LTC Waiver in order for them to continue to receive HCBS. This change will result in no loss of Medicaid coverage or services for the population.
- Establish financial and non-financial eligibility criteria (specified in section 409.904, Florida Statues) in the 1115 MMA Waiver that will enable individuals who are diagnosed with Acquired Immune Deficiency Syndrome (AIDS) to obtain and maintain Medicaid coverage without the need for enrollment in the 1915(c) PAC Waiver. This population does not need HCBS but are at risk for institutionalization without access to necessary medical/acute care services (prescribed drugs, physician services, etc.). This change enables the population to maintain access to needed services and will result in no loss of Medicaid coverage.
- Transition the federal authority to serve individuals enrolled in the 1115 MEDS-AD Waiver to the 1115 MMA Waiver. This is a technical change; the population will continue to have access to all Medicaid covered services.

The vast majority of these individuals are currently enrolled in an MMA plan for receipt of their medical, behavioral health, prescribed drugs, and dental services. The proposed changes will not affect how they receive these services or the plan in which they are enrolled.

Individuals who are transitioning to the 1915(b)/(c) LTC Waiver will have an opportunity to choose their LTC plan and will continue to have access to HCBS that are comparable to the services they are currently utilizing. In addition, the LTC program offers a more robust benefit package than the 1915(c) TBI/SCI, ACF, and PAC Waivers, including enhanced case management standards and expanded benefits. The LTC program also offers individuals an opportunity to receive care/services through a program with enhanced quality outcome measures.

The Agency is also seeking authority from the Centers for Medicare and Medicaid Services to end the 1915(c) TBI/SCI, ACF, and PAC Waivers, and the 1115 MEDS-AD Waiver once all transitions (described above) are complete.

2727 Mahan Drive • Mail Stop #8
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

The Agency is seeking federal approval to have all transitions completed by January 1, 2018.

The Agency will conduct a 30-day public comment period from August 1, 2017 through August 30, 2017. The Agency will consider all public comments received during the public notice period regarding the proposed amendments. You may view the full waiver amendment requests on the Agency's Web site at the following link: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/index.shtml.

The Agency has scheduled two public meetings to solicit meaningful input on the proposed waiver amendments. The meetings will be held in:

- Tallahassee, Florida on August 9, 2017 from 11:00 am – 12:00 pm at the Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Conference Room B, Tallahassee, FL 32308. To participate by phone, please call: 1 (877) 309-2071 and enter the participant passcode: 798-884-808. To participate by webinar, please visit: https://attendee.gotowebinar.com/register/8495210935345411.

- Tampa, Florida on August 11, 2017 from 1:00 – 2:00 pm at the Agency for Health Care Administration, 6800 N. Dale Mabry Highway, Suite 220, Main Training Conference Room, Tampa, FL 33614. To participate by phone, please call: 1 (877) 309-2071 and enter the participant passcode: 536-371-224. To participate by webinar, please visit: https://attendee.gotowebinar.com/register/3884192334985328387.

When providing comments, please include "Proposed Amendment to 1115 MMA Waiver," "Proposed Amendment to 1115 MEDS-AD Waiver," "Proposed Amendment to 1915(b)/(c) Long-term Care Waiver," or "Proposed Amendment to 1915(c) Project AIDS Care Waiver" in the subject line as appropriate:

- Submit email comments to FLMedicaidWaivers@ahca.myflorida.com.
- Submit comments by mail to Bureau of Medicaid Policy, Agency for Health Care Administration, 2727 Mahan Drive, MS 20, Tallahassee, Florida 32308.

If you have any questions about the amendment request or would like to hold a call please contact Kimberly Quinn of my staff via email at Kimberly.Quinn@ahca.myflorida.com or by phone at (850) 412-4284.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

BK/kq

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

August 10, 2017

Paul Isaacs, MD, CHFP, CHC
Executive Director, Health & Human Services
Seminole Tribe of Florida
6365 Taft Street, Suite 2004
Hollywood, FL 33024

Dear Dr. Isaacs:

The Agency for Health Care Administration sent a letter dated July 31, 2017 regarding proposed amendments to Florida's 1115 Managed Medical Assistance Waiver, 1115 MEDS-AD Waiver, 1915(c) Project AIDS Care Waiver, and 1915(b)/(c) Long-term Care Waiver. Please be advised the Tampa public meeting has been rescheduled as referenced below.

The public meeting is to solicit meaningful input on the proposed waiver amendments. The meeting will be held in Tampa, Florida on August 18, 2017 from 1:00 – 3:00 pm.

Location: The Agency for Health Care Administration
Main Training Conference Room
6800 N. Dale Mabry Highway, Suite 220
Tampa, FL 33614

To participate via telephone you may call: 1-877-309-2071
Participant Code: 536-371-224.

Participation via webinar: https://attendee.gotowebinar.com/register/3884192334985328387

If you have any questions please contact Kimberly Quinn of my staff via email at Kimberly.Quinn@ahca.myflorida.com or by phone at (850) 412-4284.

Sincerely,

Beth Kidder
Deputy Secretary for Medicaid

BK/kq

Attachment V - 1115 MEDS-AD Waiver Transition Phase-Out Plan

Statement of Purpose

The State of Florida is seeking federal authority to transition authority for the 1115 MEDS-AD Waiver (Project No. 11-W-00205/4) under the authority of Florida's 1115 Managed Medical Assistance Waiver, effective January 1, 2018. The State is currently operating the MEDS-AD Waiver under a temporary extension from the Centers from Medicare and Medicaid Services until December 31, 2017.

Background/History

In 2005, State legislation (Chapter 2005-60, Laws of Florida) directed the Agency to discontinue coverage of certain aged and disabled individuals with incomes up to 88 percent of the federal poverty level (an optional Medicaid eligibility group) under the Medicaid state plan. However, concerned that this population was at risk for costly adverse events, the Florida Legislature directed the Agency to seek a federal waiver to continue to provide benefits to a subset of the individuals in this eligibility group.

The current Florida MEDS-AD Research and Demonstration Waiver began operations in January 2006 and provides Florida Medicaid coverage for aged or disabled residents of the State of Florida with incomes at or below 88 percent of the federal poverty level and assets at or below $5,000 for an individual or $6,000 for a couple. This waiver was designed to delay or prevent the need for institutionalization of these vulnerable individuals by maintaining their level of care in the community longer through the provision of:

- Access to health care services
- High-intensity pharmacy case management services for non-institutionalized individuals and individuals not enrolled in managed care (also referred to as the Medication Therapy Management (MTM) program)

The continued coverage is designed to avoid costs of preventable hospitalizations or institutional placement that would otherwise occur had these vulnerable individuals not had access to prescribed drugs and other medical services.

Medication Therapy Management Program

The MTM program provides high intensity pharmacy case management to individuals enrolled in the MEDS-AD waiver who are not; Medicare eligible, enrolled in an MMA plan, institutionalized, or in hospice care. The recipients who elect to participate in the MTM program engage in a comprehensive medication review with a pharmacist and receive a Patient Medication Action Plan at the conclusion of the review. The results of the comprehensive medication review, along with the Patient Medication Action Plan, are sent to the recipient's

treating practitioner. Quarterly follow up calls are completed with the recipient and recommendations are communicated to the treating practitioner, as necessary. The goal of this process is to maximize opportunities for patient treatment adherence and facilitate use of evidence-based prescribing practices among treating practitioners.

There are currently approximately 50,000 recipients enrolled in the MEDS-AD Waiver. Approximately 91% are currently enrolled in, and receiving their services through, an MMA plan. The MMA plans are required to provide case management/care coordination services and programs that have similar objectives to the MTM program. To avoid duplication, only recipients who are receiving services through the fee-for-service delivery system (approximately 9% of the MEDS-AD population) are potentially eligible to participate in the MTM program. As a result, the total population that is eligible to participate in the MTM program is small and continues to diminish as more individuals elect to enroll in an MMA plan. To recruit the minimum number of MTM participants (100), the evaluation team historically has had to contact up to three times this number of individuals. Consequently, maintaining the integrity of the MTM program has become increasingly difficult given the declining eligible population, reduced interest, and the attrition rate from the waiver whereby individuals participating in the MTM program transition to another Florida Medicaid eligibility group or program prior to completing the MTM program.

Transition Plan for the MEDS-AD Population

With this amendment, the State is seeking federal approval to transition the federal and expenditure authority to serve individuals enrolled in the 1115 MEDS-AD Waiver to the 1115 MMA Waiver. This is a technical amendment request – transitioning the authority to operate the demonstration from one 1115 waiver to another. The eligibility, enrollment, and benefit design elements that are currently approved in the 1115 MEDS-AD Waiver will not substantively change under the authority of the 1115 MMA Waiver.

Eligible Population

All applicable Florida Medicaid laws or regulations apply to eligibility, and coverage of the population described below, in accordance with the Florida Medicaid state plan. Eligibility under the demonstration is limited to the following individuals not otherwise eligible for Florida Medicaid:

Demonstration Eligible Groups	Qualifying Criteria
Aged or disabled individuals – Medicaid Only	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services
Aged or disabled individuals – Medicaid Institutional	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicaid-only eligibles receiving hospice, HCBS, or institutional care services

Aged or disabled individuals – Dual Eligibles	• Income at or below 88% FPL • Assets that do not exceed $5,000 (individual) or $6,000 (couple) • Medicare Eligible • Receiving hospice, HCBS, or institutional care services

Benefits

Recipients enrolled in the demonstration receive all services offered through the state plan as well as the HCBS provided in the programs identified below in accordance with the specified authority:

- Program of All-Inclusive Care for the Elderly, section 1934 of the Social Security Act (SSA)
- Developmental Disabilities Individual Budgeting Waiver, section 1915(c), SSA
- Model Waiver, section 1915(c), SSA
- Long-term Care Waiver, section 1915(b)/(c), SSA

Availability of the home and community-based services is subject to any numeric limitation on enrollment in such programs, and the requirements that the individual meets the eligibility, and level of care criteria required to receive services through these programs.

Recipients enrolled in the demonstration will continue to receive medical/acute care services through an MMA plan, consistent with the mandatory, and voluntary participation requirements currently approved in the 1115 MMA Waiver. Recipients who do not enroll in an MMA plan will receive services through the Florida Medicaid fee-for-service delivery system.

MTM Program

The Agency will allow individuals who are currently participating in the MTM program as of July 1, 2017 to complete their term. The Agency will not enroll new participants after the current cohort of participants completes the program. Since the majority of MEDS-AD recipients are receiving services through the MMA program, and are already eligible to receive case management/care coordination through their MMA plan. The Agency believes that the goals and objectives of the MTM program are satisfied by the design and contractual requirements of the SMMC program. As such, the Agency is not requesting authority to continue the MTM program as a unique demonstration component under the 1115 MMA Waiver.

Transition Objectives

The objective of this transition is to ensure continued Florida Medicaid coverage and access to needed health care services for vulnerable populations while also achieving administrative simplifications/efficiencies through the consolidation of federal authorities.

Effect on Recipients

Individuals enrolled in the MEDS-AD Waiver will continue to be eligible for Florida Medicaid and receive their acute care services in the same manner they do now unless they choose to change MMA plan or their service provider is no longer available.

Public Notice

The State conducted the public comment period from August 1, 2017 – August 30, 2017 to solicit input on the waiver transition/phase-out request. See the "Public Notice Process" section for additional information.

Attachment VI – Federal and State Waiver Authority, Historical Description

Initial 5-Year Period (2006-2011):

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

Three-Year Extension Period (2011-2014):

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

MMA Waiver Amendment (2014):

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

Three-Year Waiver Extension (2014-2017):

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

MMA Waiver Amendment (2015):

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

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

MMA Waiver Amendment (2016):

On October 12, 2016, the Agency received approval to:

1. Allow the Agency flexibility to contract with one to three vendors under the hemophilia program.

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

MMA Waiver Extension (2016):

On December 31, 2016, the Agency submitted a request to extend authority for the 1115 MMA Waiver for an additional five years (June 30, 2017 - June 30, 2022). The extension request did not include any substantive programmatic or authority changes.

The Agency received a temporary extension to operate the MMA program through July 31, 2017.