

***PROPOSAL FOR A SECTION  
1915(b)(4) Initial Selective  
Contracting Waiver Program***

***Waiver Application Form***

**November 14, 2011**



US DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare and Medicaid Services  
Center for Medicaid and State Operations

*This streamlined waiver application form is for a State's use in requesting implementation of an initial Section 1915(b)(4) Selective Contracting waiver program.*

*While this form is primarily for use in making an initial request to implement a new 1915(b)(4) waiver, States may modify it for use in requesting a renewal of an existing 1915(b)(4) waiver program. To do so, please:*

- (1) in sections I-III, describe the program as it will be operated in the upcoming renewal period.*
- (2) provide results of monitoring activities in the previous waiver period as described in Section IV (for access and quality).*
- (3) follow the instructions in Section V for demonstrating cost-effectiveness for a renewal application.*

*The State may wish to use this standardized application form to streamline the waiver process and, thus, eliminate unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request a waiver and CMS's effort to approve the waiver proposal. Where possible, the proposal is in the form of a check-off document. However, the applicant will be required to provide detailed explanation in the space provided below each question. (Please feel free to add more space than has been provided in the original electronic document.)*

*All waiver requests under Section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on recipient access to services, and its projected impact (42 CFR 431.55(b)(2)). This model Section 1915(b)(4) waiver application form will help States provide sufficient documentation for the Secretary to be able to determine whether the statutory and regulatory requirements of Section 1915(b) of the Act have been satisfied.*

*The CMS Regional Office will be glad to meet with the State, set up a conference call, or assist the State in any way to complete the application.*

## **I. INTRODUCTION**

Please provide a short narrative description of your program in the space below (in one page or less); include the background and objective of your program, and any other information relating to your request for a Medicaid waiver:

### **Summary**

The purpose of this waiver is to allow Florida Medicaid to limit administration of the Medicaid Non-Emergency Transportation program to one (1) transportation entity serving the entire State.

The Agency for Health Care Administration (Agency) contracts with a single entity to provide statewide coordination and oversight of Florida Medicaid Non-Emergency Transportation (NET) services. This entity will ensure the provision of mandatory Medicaid non-emergency transportation services, as well as oversight and quality improvement programs for transportation of eligible Medicaid beneficiaries.

Under the contract, the Agency will pay the entity a fixed amount each month for statewide coordination of Medicaid NET services. The entity, in turn, pays subcontractors and transportation providers based on a fixed fee schedule as set forth in a contract between the entity and the subcontractors/transportation providers. From July 1, 2004 through August 31, 2012, the Agency entered into a fixed fee contract to provide NET services to Medicaid beneficiaries.

The contracting entity has the option to provide all services; provide some services and contract for the remainder; or contract for all services. The current contracting entity subcontracts all services to subcontractors in each county or region in the State. The subcontracting entity is responsible for centralized call intake, eligibility determination, authorization of trips, scheduling and dispatching trips, billing each funding source and monitoring transportation providers.

## **II. GENERAL DESCRIPTION OF THE WAIVER PROGRAM**

**A. *The State of Florida*** requests a waiver under the authority of Section 1915(b)(4) of the Social Security Act (the Act). The waiver program will be operated directly by the Medicaid agency.

**B. *Effective Dates:*** This waiver is requested for a period of 2 years; effective April 1, 2012 and ending March 31, 2014.

**C. *The waiver program is called :***

The Florida Medicaid Non-Emergency Transportation Program.

**D. *Geographical Areas of the Waiver Program:***

The waiver will be implemented in the following areas of the State:

- (1)   X   Statewide
- (2) \_\_\_\_\_ Other than statewide (List cities, counties, regions):

(Note: if the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification must be submitted to CMS.)

**E. *State Contact:*** The State contact person for this waiver is G. Douglas Harper and he can be reached by telephone at (850) 412-4210 and his email is harperg@ahca.myflorida.com.

**F. *Statutory Authority:*** The State's waiver program is authorized under **Section 1915(b)(4) of the Act** under which the State restricts the provider from or through whom a recipient can obtain medical care. Please indicate the State's reason for selectively contracting and the need for the 1915(b)(4) authority:

The objective of applying for this waiver authority is to improve the quality, cost-effectiveness, monitoring, and coordination of Medicaid Non-Emergency Transportation services. Limiting Medicaid beneficiaries' choice of transportation coordinators to a single entity will reduce unnecessary and inefficient duplication of services.

**G.** *Relying upon the authority of the above section(s), the State would like a waiver of the following Sections of 1902 of the Act:*

1.        **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State. (See item D.)
2.        **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid recipients not enrolled in the waiver program.
3.   X   **Section 1902(a)(23)** - Freedom of Choice--This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals in this waiver are constrained to receive waiver services from selected providers.
4.        **Section 1902(a)(4)** – Choice of Plans -- To permit the State to mandate beneficiaries into a single PIHP or PAHP.
5.        **Other Statutes Waived** - Please list any additional section(s) of the Act the State requests to waive, including an explanation of the request.

**H. Recipient Figures:** Please indicate the expected number of Medicaid recipients that will be impacted by the waiver:

2.6 million

I. **Waiver Populations:** The waiver is limited to the following target groups of recipients. Check all items that apply:

1.  **TANF** – Temporary Assistance to Needy Families.
2.  **TANF-Related**
3.  **SSI** - Supplemental Security Income and SSI-related.
4.  **Other** - Please describe:

### **OTHER POPULATIONS INCLUDED IN THE WAIVER**

**Medically Needy:** A Medically Needy Medicaid beneficiary is an individual who would qualify for Medicaid but has income or resources that exceed normal Medicaid guidelines. On a month-by-month basis, the individual's medical expenses are subtracted from income; if the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid through the end of the month.

**Presumptively Eligible Pregnant Women:** This program allows staff at County Health Departments, Regional Perinatal Intensive Care Centers, and other qualified medical facilities to make a presumptive determination of Medicaid eligibility for low-income pregnant women. This presumptive determination allows a woman to access prenatal care while Department of Children and Families eligibility staff make a regular determination of eligibility. Outpatient or office services related to the pregnancy are reimbursed by this program; transportation services are available to support these visits.

**Foster Care Children:** Children under the age of 21, in foster care or shelter care status.

**Institutional Care Program (ICP) Residents:** The Institutional Care Program includes Medicaid recipients who are eligible for placement in a facility (e.g., nursing home residents, etc.)

## **OTHER POPULATIONS INCLUDED IN THE WAIVER (CON'T.)**

**Medicaid recipients who receive one or more of the following services:**

- (a) A hospice program;**
- (b) A Prescribed Pediatric Extended Care (PPEC) center;**
- (c) The Aged/Disabled Waiver;**
- (d) The Assisted Living Waiver;**
- (e) The Channeling Waiver;**
- (f) The Familial Dysautonomia Waiver;**
- (g) The Model Waiver;**
- (h) The Nursing Home Diversion Waiver;**
- (i) The Project AIDS Care Waiver; or**
- (j) The Traumatic Brain Injury/Spinal Cord Injury Waiver.**

**J. Excluded Populations:** The following recipients are excluded from participation in the waiver:

1. \_\_\_\_\_ have Medicare coverage, except for purposes of Medicaid-only services;
2. \_\_\_\_\_ have other insurance;
3. \_\_\_\_\_ are residing in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR);
4. \_\_\_\_\_ have an eligibility period that is less than 3 months;
5. \_\_\_\_\_ have an eligibility period that is only retroactive;
6. \_\_\_\_\_ are eligible as medically needy;
7. \_\_\_\_\_ are eligible as foster care children;
8. \_\_\_\_\_ participate in a home and community-based waiver; or
9.  have other reasons which may exempt recipients from participating under the waiver program. Please explain:

**Excluded Populations**

- (1) Medicaid recipients who are members of a Medicaid MCO (HMO, PSN, etc.) that provides transportation.
- (2) Medicaid recipients who have their own means of transportation
- (3) Qualified Medicaid Recipients (QMB) and Special Low Income Medicare Recipients (SLMB). QMB recipients are not eligible for any Medicaid services except for Medicaid payment of their Medicare premiums, deductibles and coinsurance. SLMB recipients are not eligible for any Medicaid services except for Medicaid payment of their Part B Medicare premium.
- (4) Medicaid recipients who are domiciled or reside in a:
  - (a) Statewide inpatient psychiatric program (SIPP) facilities;
  - (b) Intermediate care facility for persons with developmental disabilities (ICF-DD);
  - (c) State Hospitals;

- (d) Correctional institutions;
  - (e) Residential commitment programs/facilities operated through the Department of Juvenile Justice (DJJ);
  - (f) Residential group care operated by the Family Safety & Preservation Program of the Department of Children & Families (DCF);
  - (g) Children's residential treatment facilities purchased through the Substance Abuse & Mental Health District (SAMH) Offices of the DCF (also referred to as Purchased Residential Treatment Services – PRTS);
  - (h) SAMH residential treatment facilities licensed as Level I and Level II facilities; and
  - (i) Residential Level I and Level II substance abuse treatment programs.
- (5) Legal aliens;
- (6) Medicaid recipients who are also members of a Medicare-funded Managed Care Organization (MCO);
- (7) Medicaid recipients who are enrolled in the Program of All-inclusive Care for the Elderly (PACE);
- (8) Enrollees in the Family Planning Waiver; and
- (9) Services provided under the following waivers:
- (a) The Developmental Disabilities Waiver (Tier 1);
  - (b) The Developmental Disabilities Waiver (Tier 2);
  - (c) The Developmental Disabilities Waiver (Tier 3);
  - (d) The Family and Supported Living Waiver (Tier 4);
  - (e) The Adult Cystic Fibrosis Waiver; and
  - (f) The iBudget Waiver.

- K. *Distance/Travel Times:*** Please define below your access standards for distance/travel times for recipients to receive services. Please explain how these travel standards differ from the without waiver travel standards:

***Distance/Travel Times Standards***

Florida has not set a maximum distance or travel time for Medicaid beneficiaries who use non-emergency transportation. A significant number of Medicaid beneficiaries live in rural areas that may offer limited access to medical care. The contracting entity/entities transport Medicaid beneficiaries out of their home counties for medical appointments as needed to obtain appropriate medical care.

Travel time standards are set in the service plan of individual counties. Area Medicaid Offices help influence this standard by participating on the Local Coordinating Boards. The Agency can monitor travel time standards by reviewing grievances received by the contracting entity/entities regarding on-time performance and assuring that the contracting entity/entities maintains records of all grievances and subsequent follow up with the Medicaid beneficiaries.

- L. *Independent Assessment:*** The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on recipient access to care of adequate quality. **This assessment is to be submitted to CMS 3 months prior to the end of the waiver period.** The Independent Assessment is required for at least the first two waiver periods. [Please refer to SMM 2111 and CMS's "Independent Assessment: Guidance to States" for more information]. Please check one of the following:

1.  This is the first or second renewal of the waiver. An Independent Assessment has been completed and submitted to CMS as required.
2.  Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

**The State need not complete an independent assessment due to the CMS on-site Compliance Review of the Florida Medicaid NET program in August 2007.**

- M. *Automated Data Processing:*** Federal approval of this waiver request does not obviate the need for the State to comply with the

Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C; 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

### **III. PROGRAM IMPACT:**

In this section, please provide information on (1) affected recipients, (2) services, and (3) waiver providers.

#### **A. Affected Recipients**

- 1. Notification Process:** Please explain below in detail the process through which recipients will be notified of the waiver program provisions:

#### **NOTIFICATION PROCESS**

During eligibility determination, the Department of Children and Families provides information on available services, including transportation. In addition, each county conducts outreach activities to advise transportation disadvantaged citizens, including Medicaid recipients, of the availability of transportation services and how to access those services. Outreach efforts include brochures, newsletters, and, in some counties, public service announcements.

The contracting entity and its Subcontracting Transportation Providers (STPs) are responsible for development and issuance of a non-emergency transportation handbook for Medicaid beneficiaries, regarding NET services. The contracting entity must submit its non-emergency transportation handbook to the Agency within thirty (30) calendar days following contract execution. The education and outreach plan, at a minimum, must include:

- STP contact information;
- Directions on use of NET services offered by the contracting entity or its STPs;
- Medicaid beneficiaries' rights and responsibilities for use of NET services; and
- Medicaid beneficiaries' grievance, appeal, and Medicaid Fair Hearing procedures.

The contracting entity must make oral interpretation services available free of charge to non-English speaking Medicaid beneficiaries. Interpretation services apply to all non-English languages, not just those that the State identifies as prevalent. The contracting entity cannot charge Medicaid beneficiaries for interpretation services. The contracting entity must notify Medicaid beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services.

Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The contracting entity must inform all transportation eligible Medicaid beneficiaries that information is available in alternative formats and how to access those formats.

**2. *Recipient's Choice of Providers.*** If more than one provider is selected per geographical area, please address the following points:

- (a) Will recipients be given the choice of selected providers? If so, how will they select a provider, and how will the provider be informed of the recipient's choice?

***No. There will be only one provider.***

- (b) How will beneficiaries be counseled in their choice of waiver providers?

***N/A.***

- (c) How will the recipient notify the State of provider choice?

***N/A.***

- (d) Define the time frames for recipients to choose a waiver provider:

***N/A.***

- (e) Will the recipients be auto-assigned to a waiver provider if they do not choose? Yes \_\_\_\_\_ No \_\_\_\_\_

***N/A.***

- (i) If so, how many days will they have to choose?

***N/A.***

- (ii) Describe below the auto-assignment process and/or algorithm:

***N/A.***

**3. *Implementation Process***

- (a) Will implementation occur all at once?

Yes

No. Please describe below the time frames for implementation, including time frames for inclusion of current Medicaid recipients:

(b) Will there be accommodations for special-needs populations such as the disabled, etc.?

Yes. Please explain below:

No

4. **Education Materials:** Please include with this application a copy of all relevant recipient education materials, including the **initial notification letter** from the State. Also, check the items which will be provided to the recipients:

- a.  a **brochure** explaining the program;
- b.  if more than one provider is selected per geographical area, a **form** for selection of a provider;
- c.  if more than one provider is selected per geographical area, a **list of qualified providers** serving the recipient's geographical area;
- d.  a **new Medicaid card** which includes the provider's name and telephone number or a **sticker** noting the provider's name and telephone number to be attached to the original Medicaid card (please specify which method);
- e.  a **brief presentation and informing materials** to each new recipient describing how to appropriately access services under the waiver program, including the appropriate usage of emergency rooms and family planning services, and how to exercise due process rights;

and

f. X other items (please explain below):

(1) Medicaid Beneficiary Education for Accessing Services

- (a) During Medicaid eligibility determination, the Department of Children and Families provides information on available services, including transportation. In addition, each county conducts outreach activities to advise transportation disadvantaged Medicaid recipients of the availability of transportation services and how to access those services.

(2) Outreach

- (a) Outreach efforts will include notifying Medicaid beneficiaries that there are several initial points of entry for referrals for this service; Medicaid beneficiaries may contact the contracting entity, which may then refer calls to a Subcontracting Transportation Provider (STP) for the determination of transportation eligibility and the subsequent arrangement of services.
- (b) The contracting entity must make available for distribution to the public a program information flyer informing Medicaid beneficiaries of important phone numbers, the policies and procedures for requesting services, and the grievance, appeal, and Medicaid Fair Hearing procedure. Medicaid beneficiaries may contact their local STP for non-emergency transportation information.
- (c) To inform and educate Medicaid beneficiaries, the contracting entity must provide the following information to current Medicaid NET beneficiaries within thirty (30) days of execution of the contract, to Medicaid beneficiaries accessing NET services for the first time, and upon a Medicaid beneficiary's request:

- contracting entity or STP contact information;
- The process to apply for Medicaid NET services;
- Medicaid beneficiary rights and responsibilities;
- The contracting entity's No-Show and Cancellation Policy;
- The contracting entity's Medicaid NET Grievance and Appeal Resolution Policy and Fair Hearing Policy;
- The contracting entity's Medicaid NET Denial of Service process; and
- The contracting entity's Medicaid NET Intake Form.

(d) The intake form is a tool used to determine a Medicaid beneficiary's eligibility for NET services and the appropriate mode of transportation.

(3) Accessibility of Information

(a) The contracting entity, or its STP, shall provide adequate staff and telephone lines to all incoming calls, including TTY calls. The contracting entity may utilize a telephone answering machine or electronic voice mail when offered as an option to the Medicaid beneficiary; however, the contracting entity shall give Medicaid beneficiaries the option of staying in queue or reaching a staff person.

(b) The contracting entity, or its STP, will ensure oral interpretation services are available, free of charge, to non-English speaking Medicaid beneficiaries. This applies to all non-English languages, not just those that the State identifies as prevalent. Neither the contracting entity, nor its STP, may charge Medicaid beneficiaries for interpretation services. The contracting entity, or its STP, will notify Medicaid beneficiaries that oral interpretation is available for any language, that written information is available in

prevalent languages, and how to access those services.

- (c) The contracting entity, or its STP, will make available written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The contracting entity, or its STP, will inform all Medicaid beneficiaries and potential Medicaid beneficiaries that information is available in alternative formats and how to access those formats.

- 5. **Languages.** The State has made a concerted effort to determine if and where significant numbers of non-English speaking recipients reside, and has subsequently made the program educational materials available in the native languages of those groups. Please describe your activities below:

All transportation information is available in all languages that are prevalent in each county and are free of charge to Medicaid Beneficiaries.

**B. Services:**

- 1. **Description of Services:**

Please identify below the Medicaid services which will be affected by the selective contracting process:

Non-Emergency Transportation services to Medicaid compensable services.

- 2. **Emergency and Family Planning:** In accordance with regulations, freedom of choice of provider in cases of emergency and family planning services will not be restricted.

### **C. Selection and Availability of Providers**

- 1. Selection Criteria:** Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

#### **PROVIDER SELECTION CRITERIA**

- (1) Pursuant to Florida Statute, the Agency entered into contract negotiations with the contracting entity to provide transportation services.
- (2) The contracting entity was already coordinating transportation for people statewide at the time the Agency entered into contract with it. The service population included people with disabilities and those unable to afford their own transportation.
- (3) The contracting entity had an experienced network of providers in place to service all eligible Medicaid beneficiaries in every county.

- 2. Numbers and Types of Qualifying Providers:** For each of the services covered by the selective contracting waiver, please list in the chart below the numbers of Medicaid providers expected under the waiver compared with what existed prior to the waiver:

Also, please provide in the space below the chart a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver:

For non-institutional services provided by an “entity” (i.e. versus an independent practitioner), please provide information below as to the numbers of actual care-givers per entity that will be available to provide the waiver service(s):

**Capacity Analysis:**

<b>County</b>	<b>2009 Total Vehicles</b>	<b>2009 Wheelchair Vehicles</b>	<b>2009 Stretcher Vehicles</b>	<b>2010 Total Vehicles</b>	<b>2010 Wheelchair Vehicles</b>	<b>2010 Stretcher Vehicles</b>
ALACHUA	41	41	3	41	40	3
BAKER	13	13	0	17	16	0
BAY	38	31	2	38	28	2
BRADFORD	14	14	1	14	14	1
BREVARD	167	61	0	182	97	0
BROWARD	340	197	0	491	263	0
CALHOUN	13	5	1	15	5	2
CHARLOTTE	45	28	2	45	28	0
CITRUS	76	45	11	73	41	18
CLAY	36	27	1	46	33	1
COLLIER	27	25	2	27	25	2
COLUMBIA (1)	27	25	2	56	36	9
DADE	797	263	0	836	298	0
DESOTO	21	13	1	19	12	1
DIXIE	8	8	2	8	8	2
DUVAL	92	92	0	80	80	0
ESCAMBIA	39	14	2	28	16	2
FLAGLER	30	23	0	28	23	0
FRANKLIN	14	5	0	14	6	1
GADSDEN	22	12	1	21	11	1
GILCHRIST	8	8	2	8	8	2
GLADES (2)	2	2	0	2	2	0
GULF	13	9	1	12	9	1
HAMILTON (1)	14	7	2	14	7	2
HARDEE	14	10	1	14	10	1
HENDRY (2)	18	10	1	19	11	1
HERNANDO	63	32	5	67	36	5
HIGHLANDS	54	42	3	52	38	2
HILLSBOROUGH	260	140	3	267	148	3
HOLMES	21	6	1	22	6	1
INDIAN RIVER	70	66	3	65	62	4
JACKSON	10	8	1	27	11	1
JEFFERSON	10	8	1	10	8	1
LAFAYETTE	7	6	1	7	6	1
LAKE	95	55	2	91	72	2
LEE	47	46	1	66	41	1
LEON	28	22	1	19	15	2
LEVY	18	17	3	25	22	2
LIBERTY	19	5	1	19	5	1
MADISON	17	9	2	16	9	1
MANATEE	65	48	1	56	51	0
MARION	94	60	11	86	60	8
MARTIN	94	54	7	57	33	1

County	2009 Total Vehicles	2009 Wheelchair Vehicles	2009 Stretcher Vehicles	2010 Total Vehicles	2010 Wheelchair Vehicles	2010 Stretcher Vehicles
MONROE	46	21	0	52	23	1
NASSAU	16	13	1	19	17	1
OKALOOSA	65	43	1	65	43	1
OKEECHOBEE	14	7	1	15	9	1
ORANGE (3)	234	137	3	226	141	3
OSCEOLA (3)	62	36	1	60	37	1
PALM BEACH	246	246	0	311	311	0
PASCO	119	28	6	116	30	6
PINELLAS	672	184	9	733	221	11
POLK	151	84	8	156	86	8
PUTNAM	33	24	2	32	27	5
SANTA ROSA	14	4	1	10	5	1
SARASOTA	115	78	0	99	88	0
SEMINOLE (3)	57	34	1	55	35	1
ST. JOHNS	46	39	3	48	39	3
ST. LUCIE	170	54	3	119	52	0
SUMTER	45	42	7	52	44	6
SUWANNEE (1)	43	28	9	43	28	9
TAYLOR	17	11	2	14	9	1
UNION	10	4	1	11	4	1
VOLUSIA	98	71	4	100	75	0
WAKULLA	11	5	1	8	5	1
WALTON	25	6	1	26	6	1
WASHINGTON	22	6	1	22	5	1
STATE TOTAL	5,276	2,829	158	5,492	3,090	151
Change				+216	+261	-17

- (1) Columbia, Hamilton and Suwannee are totaled under Columbia.  
(2) Glades and Hendry are totaled under Glades.  
(3) Orange, Osceola and Seminole are totaled under Orange.

3. **Program Requirements.** Below is a description of provider qualifications and requirements under the waiver. Providers **must**:

- a.  **be Medicaid qualified providers** and agree to comply with all pertinent Medicaid regulations and State plan standards regarding access to care and quality of service and meet general qualifications for enrollment as a Medicaid provider;
- b.  **not refuse to provide services** to a waiver participant or otherwise discriminate against a participant solely on the basis of age, sex, race, physical or mental handicap,

national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type; and

c.   X   **other qualifications (Please describe):**

The Agency does not require the enrollment of transportation operators who provide NET services to Medicaid beneficiaries under a contract with the contracting entity as Medicaid providers. They are still required to comply with all pertinent Medicaid regulations, the State plan standards, meet general provider standards for enrollment, and comply with the requirements of the contract.

**COORDINATOR/PROVIDER STANDARDS**

In the event the contracting entity subcontracts part or all of its transportation duties to one or more Subcontracting Transportation Coordinators (STCs), the contracting entity must ensure that the STCs offer, maintain, and satisfactorily deliver the following services:

**Recruiting and Negotiating**

Establish a network of Non-Emergency Transportation (NET) providers to deliver transportation.

**Payment Administration**

Provide payment to each transportation operator based on authorized services rendered, in accordance with Section 215.422, Florida Statutes.

**Gatekeeping**

Determine Medicaid beneficiary eligibility; assess Medicaid beneficiary need for NET services; determine the most appropriate transportation method to meet each Medicaid beneficiary's need (including any special transport requirements for Medicaid beneficiaries who are medically fragile or who have physical or mental impairments); and provide education to Medicaid beneficiaries on the use of NET services as stated in the contracting entity's Gatekeeper Policy.

**Reservations and Trip Assignments**

Assure that scheduling and dispatching are consistent with the most appropriate mode of transport that meets the needs of the Medicaid beneficiary.

**Quality Assurance**

Provide assurance that transportation providers meet health and safety standards for vehicle maintenance, operation, and inspection; driver qualifications and training; Medicaid beneficiary Grievance, Appeal, and

Medicaid Fair Hearing requirements; and the delivery of courteous, safe, and timely transportation services.

#### **Encounter Data Collection**

The contracting entity must maintain an extensive, secure database capable of collecting and holding, for each transport, the data elements outlined in the contract.

#### **Administrative Oversight/Reporting**

Responsible for the management of overall day-to-day operations necessary for the delivery of NET services and the maintenance of appropriate records and systems of accountability to report to the Agency and respond to the terms of the contract.

#### **Covered Services**

In accordance with federal regulations (42 CFR 431.53), NET services are defined as transportation for any Medicaid beneficiary, and up to one personal care attendant/escort, with no other available means of transportation, to medically necessary and Medicaid compensable services.

The contracting entity must provide, or ensure provision of, Non-Emergency Transportation (NET) services to eligible Medicaid beneficiaries for Medicaid compensable medical appointments by utilization of the appropriate mode of transportation including, but not limited to, the following:

- Multiload Vehicles;
- Wheelchair Vehicle;
- Stretcher Vehicle;
- Public Transportation;
- Over-the-Road Bus;
- Private Volunteer Transportation;
- Escort Services; and
- Commercial Air Carrier Transportation.

#### **Subcontracted Transportation Coordinator Minimum Performance Standards**

The Subcontracted Transportation Coordinators (STCs) shall adhere to performance standards described in their subcontracts with the contracting entity pertaining to:

- Medicaid Beneficiary Access
  - Policies and Procedures to facilitate access to NET services.

- Eligibility Screening
  - Review and document Medicaid beneficiary eligibility to receive services under the contract.
- Transportation Standards
  - Provide appropriate cost-effective transportation in compliance with applicable laws and regulations.
- Appropriate Level of Transportation
  - Refer emergency calls to 911 or an ambulance service, as appropriate.
- Activity Documentation
  - Must retain and make available specified documents for at least five (5) years past the termination of the contract.
- Service Standards
  - Must comply with all applicable local, State, and Federal laws and regulations.
- Vehicle Inspections
  - Must comply with all local, State, Federal, and contractual requirements pertaining to vehicle maintenance and record keeping.
- Personnel
  - STCs are responsible for the work performed by their employees and for complying with all applicable local, State, and Federal regulations regarding employment.
- Gatekeeper Policy
  - Have in place a policy to appropriately determine a Medicaid beneficiary's eligibility for transportation services.
- Fraud Prevention Policies and Procedures
  - Develop and maintain written policies and procedures on fraud prevention as specified in the contract.

The Agency must approve the contracting entity's Model Transportation Provider Agreements to ensure the inclusion of the above.

4. ***Provider/ Beneficiary Ratio:*** Please calculate and list in the chart below the expected average provider/beneficiary ratio for each geographical area or county of the program, and then provide a statewide average and how it differs from the regular Medicaid program:

County	2009 Operator to Recipient Ratio	2010 Operator to Recipient Ratio
ALACHUA	1 : 1,243	1: 980
BAKER	1 : 114	1: 117
BAY	1 : 1,237	1: 1,225
BRADFORD	1 : 239	1: 224
BREVARD	1 : 1,762	1: 1,833
BROWARD	1 : 2,735	1: 1,856
CALHOUN	1 : 366	1: 327
CHARLOTTE	1 : 733	1: 572
CITRUS	1 : 796	1: 664
CLAY	1 : 485	1: 380
COLLIER	1 : 1,008	1: 597
COLUMBIA (1)	1 : 2,856	1: 3192
DADE	1 : 4655	1: 4,114
DESOTO	1 : 380	1: 450
DIXIE	1 : 192	1: 175
DUVAL	1 : 2,180	1: 2,155
ESCAMBIA	1 : 1,064	1: 934
FLAGLER	1 : 264	1: 351
FRANKLIN	1 : 128	1: 112
GADSDEN	1 : 433	1: 437
GILCHRIST	1 : 107	1: 106
GLADES (2)	1 : 886	1: 469
GULF	1 : 135	1: 151
HAMILTON (1)	1 :	1:
HARDEE	1 : 294	1: 348
HENDRY (2)	1 :	1:
HERNANDO	1 : 1,579	1: 1,307
HIGHLANDS	1 : 2,218	1: 1,006
HILLSBOROUGH	1 : 5,050	1: 6,391
HOLMES	1 : 440	1: 444
INDIAN RIVER	1 : 444	1: 505
JACKSON	1 : 623	1: 634
JEFFERSON	1 : 249	1: 195
LAFAYETTE	1 : 64	1: 56
LAKE	1 : 850	1: 791
LEE	1 : 1,538	1: 1,531
LEON	1 : 520	1: 476
LEVY	1 : 577	1: 384
LIBERTY	1 : 122	1: 133
MADISON	1 : 217	1: 205

MANATEE	1 : 999	1: 1,081
MARION	1 : 2,579	1: 2,011
MARTIN	1 : 371	1: 472
MONROE	1 : 632	1: 333
NASSAU	1 : 335	1: 276
OKALOOSA	1 : 658	1: 708
OKEECHOBEE	1 : 411	1: 412
ORANGE (3)	1 : 4,903	1: 5459
OSCEOLA (3)	1 :	1:
PALM BEACH	1 : 1,885	1: 1,925
PASCO	1 : 2,041	1: 2,275
PINELLAS	1 : 9,302	1: 10,104
POLK	1 : 2,130	1: 2,014
PUTNAM	1 : 821	1: 824
SANTA ROSA	1 : 277	1: 133
SARASOTA	1 : 821	1: 931
SEMINOLE (3)		1:
ST. JOHNS	1 : 728	1: 743
ST. LUCIE	1 : 797	1: 1,043
SUMTER	1 : 427	1: 219
SUWANNEE (1)	1 :	1:
TAYLOR	1 : 140	1: 126
UNION	1 : 357	1: 151
VOLUSIA	1 : 2,750	1: 1,431
WAKULLA	1 : 101	1: 82
WALTON	1 : 538	1: 595
WASHINGTON	1 : 332	1: 429
STATE TOTAL	1 : 73,118	1: 69,604

- (1) Columbia, Hamilton and Suwannee are totaled under Columbia.
- (2) Glades and Hendry are totaled under Glades.
- (3) Orange, Osceola and Seminole are totaled under Orange.

5. **Change of Provider:** Please answer the following questions regarding beneficiary changes of providers and/or actual care-givers:

a. **Change of Providers:**

If there is more than one selected provider per geographical area, can the beneficiaries change providers?

\_\_\_\_\_ No. Please explain:

\_\_\_\_\_ Yes. Please describe the process, reasons, etc.:

N/A

The Agency will contract with only one (1) contracting entity either for a statewide contract or for a region of Florida (i.e., North Florida, Central Florida, and South Florida). The contracting entity will arrange transportation for the Medicaid beneficiaries.

b. **Change in Actual Care-givers:**

- (l) For non-institutional waiver services provided by an "entity," can the beneficiaries change their individual care-givers within the selected provider?

\_\_\_\_ No. Please explain:

X  Yes. Please describe the process, reasons, frequency, etc.:

**CHANGING INDIVIDUAL OPERATORS WITHIN THE WAIVER PROVIDER GROUP**

The contracting entity will arrange all Medicaid non-emergency transportation (NET) between the transportation providers and the Medicaid beneficiaries. Together, the parties will determine the most cost-effective and efficient means of transportation while providing all necessary medical services. If a Medicaid beneficiary has difficulty with a particular transportation provider, he/she should report the provider to the contracting entity for investigation.

**6. Provider's Change of Beneficiary:** Please answer the following questions regarding provider changes of beneficiaries:

- a. If more than one provider is selected per geographical area, can providers request to reassign a beneficiary from their care?

No \_\_\_\_\_

Yes \_\_\_\_\_

If yes, **it is important that reasons for reassignment are not discriminatory in any way toward the patient.** In cases of beneficiary change, the reassignment should be agreed upon by the beneficiary as well. The following are acceptable reasons for reassignment. Please check the ones that apply to the State's program and explain those that differ:

(1)\_\_\_\_\_patient/provider relationship is not mutually acceptable;

(2)\_\_\_\_\_patient's condition or illness would be better treated by another provider type; or

(3)\_\_\_\_\_Other reasons (Please explain):

**N/A**

The Agency will contract with only one (1) contracting entity either for a statewide contract or for a region of Florida (i.e., North Florida, Central Florida, and South Florida). The contracting entity will arrange transportation for the Medicaid beneficiaries.

*b. If the reassignment is approved*, the State must notify the beneficiary in a direct and timely manner of the desire to remove the beneficiary from his/her caseload, and must keep the participant as a client until another provider is chosen or assigned. Please specify below if the State's policy differs in any way from those listed above:

**7. Reimbursement of Providers:** Please explain how the State pays providers under the waiver program. Include whether providers are pre-paid, how often paid, and what is the basis of payment (if payment is made per ride, beneficiary, or service rendered):

### **Reimbursement of Providers**

The Agency will pay the contracting entity a fixed fee amount each month for statewide or regional coordination of Medicaid Non-Emergency Transportation (NET) services. The contracting entity, in turn, will pay the transportation providers in each county based on the amount agreed upon in the Transportation Provider Agreement between the contracting entity and the transportation provider.

NET services are mandatory Medicaid services that cannot be restricted if the person qualifies for NET services. Through a contract with the Agency, the contracting entity accepts responsibility to provide or coordinate delivery of all NET services within the existing funds of this contract. Administrative fees are limited to no more than five (5%) percent of total contract amount. The contracting entity must pay the remaining ninety-five (95%) percent of the contract amount to transportation providers.

In the event transportation costs are greater than the 95% allotted, any retained surplus may be used to cover the actual costs for services. If sufficient surplus is not available, the contracting entity will continue to provide or coordinate delivery of all NET services through its own funds.

No later than November 30 of each contract year, the contracting entity shall provide the Agency with a transportation payment reconciliation to determine if the contracting entity has remaining surplus funds above the five (5%) percent threshold, based on the previous State fiscal year. The contracting entity will return any surplus funds to the Agency, which, in turn, will distribute the funds between the Centers for Medicare and Medicaid Services (CMS), the Agency, and the contracting entity in the following manner: CMS will receive the total federal match percentage; then, the Agency will retain 50% of the current state match percentage; and the contracting entity will receive 50% of the current state match percentage.

#### **IV. ACCESS TO CARE AND QUALITY OF SERVICES:**

- A. General:** The beneficiary's access to quality medical services must at a minimum not be adversely affected by a 1915(b)(4) waiver program. A waiver must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the individuals enrolled under the waiver. Furthermore, access to emergency services and family planning services must not be restricted.
- B. Grievance Process:** Please describe the process that will be in place to handle complaints and grievances under the waiver program. Please discuss how this will compare to the regular Medicaid program. **NOTE: Beneficiaries must have available and be informed of a formal appeals process under 42 CFR Part 431, Subpart E which may lead to a Fair Hearing.** Please fully describe:

##### **Grievance Process**

The contracting entity must have written policies and procedures detailing the contracting entity's Grievance Process. The contracting entity must maintain an Ombudsman helpline to provide Medicaid beneficiaries with an avenue to voice concerns about the coordinated transportation system and Medicaid Non-Emergency Transportation, and also as a means to provide information about the Transportation Disadvantaged program. The contracting entity is responsible for ensuring that every vehicle has a sticker posted in a prominent place listing the contracting entity's Ombudsman helpline.

The helpline is a part of the Quality Assurance Program. The contracting entity's Ombudsman staff perform call intake, listen to and document concerns of the Medicaid beneficiaries, provide Medicaid beneficiaries with information, refer Medicaid beneficiaries to the appropriate local area office, and maintain a database on information from all callers. The Ombudsman staff will follow-up with the Medicaid beneficiaries to ensure their concerns were addressed. The contracting entity must perform routine monitoring to assure that this number is available in all vehicles and in alternative formats (i.e., Braille, large print).

The contracting entity must obtain the Agency's written approval for all notices explaining the contracting entity's grievance and appeal process to each Medicaid beneficiaries. The contracting entity must send notice of the grievance and appeal process at the same time it sends a denial or limitation of services to a Medicaid beneficiary. The contracting entity is also responsible for entering the notice of denial or limitation into its records.

Each Medicaid beneficiary has the right to appeal any decision made regarding adequacy of service, the quality of service, or perceived denial of service. The

contracting entity must notify the local Medicaid office, and the contracting entity's staff is responsible for coordinating a hearing in the Medicaid beneficiary's community with an official Hearings Officer. The contracting entity resolves many grievances (complaints) without a formal hearing. The contracting entity may appoint a Grievance Committee to provide less stringent steps between the filing of grievances (complaints) and the holding of hearings.

If the contracting entity is unable to resolve the grievance (complaint) through its grievance procedures, as stated above, the Medicaid beneficiary may request a Medicaid Fair Hearing. Medicaid beneficiaries may bypass the grievance process and request a Medicaid Fair Hearing.

### ***C. Monitoring Access:***

- 1. Service Access Areas:** Please explain in detail the State's plans to monitor and improve the following areas of service access:

#### **SERVICE ACCESS AREAS MONITORING**

The State of Florida has many ways to monitor service access for Medicaid beneficiaries participating in the Non-Emergency Transportation (NET) program. The Agency shall evaluate the contracting entity to ensure access to services is adequate and that the service quality is acceptable to the community. The Agency conducts annual reviews of the contracting entity. The contracting entity conducts rider surveys; typical questions include timeliness of pickup, attitude of driver and reservation staff, cleanliness/consistent appearance of driver and vehicle, and resolution of grievances (complaints).

The contracting entity maintains a toll-free hotline for grievances (complaints), including follow-up to determine if the contracting entity was able to reach a final resolution and if all staff involved in the process were helpful. In addition, the contracting entity reports and compiles data into the Annual Performance Report, allowing for county-by-county comparisons.

The Agency is able to review this information to monitor service access areas. The contracting entity conducts periodic rider surveys to monitor service access areas. These monitoring tools allow the Agency to access information related to time and distance, waiting times to obtain NET services, provider-to-Medicaid beneficiary ratios, and Medicaid beneficiary knowledge of how to appropriately access waiver services and how to access to urgent or emergency services.

- 2. Procedure for Monitoring:** Beneficiary access to care will be monitored during the waiver period by the State as indicated below. Records will be maintained to identify lack of access trends and for reporting purposes. Check which monitoring activities will be in effect to assure that beneficiary access to care is not substantially

impaired. Also, identify the means the State will employ to intervene to correct problems. If any of the following differ from the State's program, please indicate and explain:

- a. \_\_\_\_\_ **An advisory committee** will be designated during the phase-in period to address beneficiary and provider concerns.
- b. X **Hotline** with an 800 number will be maintained which handles any type of inquiry, complaint, or problem.
- c. \_\_\_\_\_ **Periodic comparison** of the numbers of providers available to the Medicaid recipients before and under the waiver will be conducted. The intent of this review is to identify whether the waiver may have reduced access to specific types of providers. Also, for non-institutional services, a periodic comparison will be made of the individual care-givers within an "entity", where applicable, in order to ensure that the same level of access is maintained throughout the waiver period.
- d. X **Periodic beneficiary surveys** (which will contain questions concerning the beneficiaries' access to all services covered under the waiver) will be mailed to a sample of waiver recipients.
- e. \_\_\_\_\_ **Other** (Please explain):

**D. Monitoring Quality of Services:** Please explain in detail the State's plans to monitor and assure quality of services under the waiver program. Please describe how will the State monitor the following:

- 1. \_\_\_\_\_ **Beneficiaries' reasons for changing providers** in order to detect quality of care problems (not only actual changes, but requests to change specific individual care-givers and/or providers):
- 2. X **Hotline**:
- 3. X **Periodic beneficiary surveys** (which question the quality of services received under the waiver) are mailed to a sample of waiver recipients:
- 4. X **Complaints**, grievance and appeals system:

5. \_\_\_ Other (Please explain):

**E. Other Quality Monitoring:**

1. **Quality of Services** will be further monitored through the mechanisms outlined below. Quality of services problems identified will result in a desk review or an onsite medical review to resolve the problems.

**Quality of Service Monitoring**

**SCOPE OF WORK FOR PERIODIC REVIEWS**

The Agency shall conduct annual desk reviews and onsite surveys of the contracting entity. The Quality Assurance activities address public safety and health issues for Medicaid beneficiaries who receive services under the Non-Emergency Transportation (NET) program. As part of the annual review, Agency staff will provide recommendations for implementation of any necessary changes. The recommendations address cost efficiency and effectiveness in operations, along with quality of service issues.

The Agency's on-site evaluation includes, but is not limited to, the following: the review of the contracting entity's compliance with the Americans with Disabilities Act; a review of the contracting entity's monitoring efforts for its contracted transportation providers to ensure compliance with federal, state, and local requirements and standards.

Another aspect of the monitoring is the contracting entity's fraud and abuse prevention program and the contracting entity's ability to detect potential abuse of riders by transportation providers or Medicaid beneficiaries. Investigations relating to these activities may be initiated as a result of information from the contracting entity and its staff, the Legislature, consumers, the Ombudsman Program, or other federal, state, or local agencies.

The Ombudsman Program is key to the monitoring effort because of the ability to identify potential problems in real-time. The primary goal of this program is to give consumers a forum to express concerns relating to services, as well as to provide contracting entity staff with a tool to improve policies and program implementation. Ombudsman staff can perform call intake; listen and document concerns of the Medicaid beneficiaries; provide Medicaid beneficiaries with information; refer Medicaid beneficiaries to the appropriate local STP for resolution of the issue; and maintain a database on information from all Medicaid beneficiaries.

2. **Periodic reviews:** Please describe what areas will be covered in the State's periodic reviews of claims files and medical audits, be resolved. Please include how often these reviews will take

place:

## **Reports**

Transportation providers no longer file fee-for-service claims for Medicaid NET services. The Agency pays the contracting entity a capitated amount each month for statewide or regional coordination of Medicaid NET services. The Agency requires the contracting entity to prepare monthly, quarterly and annual reports on encounter data as well as grievances (complaints) filed and corrective action taken. The Agency may require the contracting entity to provide immediate response to ad hoc data requests.

### **Monthly Reports**

The contracting entity must submit a summary spreadsheet of encounter data including a summary of all reimbursements for NET services by county, during the report month and year-to-date totals.

#### **Summary of Monthly Tables**

The contracting entity must submit the following reports on a monthly basis:

- (1) Suspected Fraud Reporting (immediately upon occurrence);
- (2) Critical Incidents (immediately upon occurrence);
- (3) Systems Outage Report (if applicable);
- (4) Minority Subcontractor Participation Report;
- (5) Trip Travel Expense Report; and
- (6) Performance Measures Report.

### **Quarterly Reports**

A summary of the contracting entity's Quality Financial Report and findings for that quarter.

A grievance and appeal report, a sub-listing of all current NET related complaints, grievances, appeals and Medicaid Fair Hearings

An account of all current contracts between the contracting entity and minority and women-owned business enterprises (MWBE) and an account of all pending contracts showing the inclusion of advertisement to minority businesses noting the company names, contacts, representation, number of trips, and total dollars paid to the MWBE.

### Summary of Reports

- (1) Grievance System Reporting; and
- (2) Unaudited Quarterly Financial Reporting;

### Annual Reports

The contracting entity must submit to the Agency an annual performance report in accordance with OMB Circular A-133 that summarizes NET services provided during the contract period.

#### Summary of Annual Reports

- (1) Medicaid Beneficiary Satisfaction Survey Summary;
- (2) Safety Compliance Self Certification Report;
- (3) Quality Improvement;
- (4) Annual Reconciliation Report;
- (5) Allocation Methodology Report;
- (7) Performance Measures;
- (8) Audited Financial Report; and
- (9) Total direct cost (agency manager, staff, salary, rent), profit margin and/or retained earnings, allocation of indirect expenditures, and total transportation costs.

### Ad Hoc Reporting

The contracting entity must provide reports to the Agency in response to requests for data on a periodic basis. The Agency may require the contracting entity to provide additional information in the annual, quarterly, and monthly reports when specified by the Agency.

3. **State Intervention:** If a problem is identified regarding access to care and quality of services problems, the State will intervene as noted below (please indicate which of the following the State utilizes:

- (a) \_\_\_\_\_ Education and informal mailing

- (b)  Telephone and/or mail inquiries and follow-up
- (c)  Request that the provider respond to identified problems
- (d)  Referral to program staff for further investigation
- (e)  Warning letters
- (f)  Referral to State's medical staff for investigation
- (g)  Corrective action plans and follow-up
- (h)  Change beneficiary's provider
- (i)  Restriction on types of beneficiaries
- (j)  Further limits of the number of assignments
- (k)  Ban on new assignment of beneficiaries
- (l)  Transfer of some or all assignments to a different provider
- (m)  Suspension or termination as a waiver provider
- (n)  Other (Please explain):

## **Section C. Cost-Effectiveness**

### **FL CE-10/10/11**

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section C. State Completion Section of the Preprint:

- Appendix C1.** Member Months
- Appendix C2.S** Services in the Actual Waiver Cost
- Appendix C2.A** Administration in the Actual Waiver Cost
- Appendix C3.** Actual Waiver Cost
- Appendix C4.** Adjustments in Projection
- Appendix C5.** Waiver Cost Projection
- Appendix C6.** RO Targets
- Appendix C7.** Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

### **Part I: State Completion Section**

#### **A. Assurances**

- a. [Required] Through the submission of this waiver, the State assures CMS:
  - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
  - The State assures CMS that the actual waiver costs will be less than or equal to the State's waiver cost projection.
  - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
  - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
  - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

**C. Capitated portion of the waiver only: Type of Capitated Contract**

The response to this question should be the same as in A.I.b.

- a.  MCO
- b.  PIHP
- c.  PAHP
- d.  Other (please explain):

**D. PCCM portion of the waiver only: Reimbursement of PCCM Providers**

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

- a.  Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
  - 1.  First Year: \$  per member per month fee
  - 2.  Second Year: \$  per member per month fee
  - 3.  Third Year: \$  per member per month fee
  - 4.  Fourth Year: \$  per member per month fee
- b.  Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c.  Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under D.I.H.d., please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.  Other reimbursement method/amount. \$  Please explain the State's rationale for determining this method or amount.

**E. Appendix C1 – Member Months**

Please mark all that apply.

For Initial Waivers only:

- a.  Population in the base year data
  - 1.  Base year data is from the same population as to be included in the waiver.
  - 2.  Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

in **Appendix C5**. Explain the differences here and how the adjustments were made on **Appendix C5: There are no changes in waiver services. Therefore, no adjustments were made within the cost effectiveness projection.**

- b.  [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: **No services have been excluded.**

**G. Appendix C2.A - Administration in Actual Waiver Cost**

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.

For Initial Waivers:

- a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	\$54,264 savings or .03 PMPM	9.97% or \$5,411	\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2
Total	<i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i>		<b>(PMPM in Appendix D5 Column W x projected member months should correspond)</b>

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix C3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix C5**.

c. N/A Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:  
Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method: N/A

1. \_\_\_ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. \_\_\_ The State provides stop/loss protection (please describe):

d. N/A Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. \_\_\_ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
  - i. Document the criteria for awarding the incentive payments.
  - ii. Document the method for calculating incentives/bonuses, and
  - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.
2. \_\_\_ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)
  - i. Document the criteria for awarding the incentive payments.
  - ii. Document the method for calculating incentives/bonuses, and
  - iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

3. \_\_\_ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

- i. \_\_\_ Please indicate the years on which the utilization rate was based (if calculated separately only).
- ii. \_\_\_ Please document how the utilization did not duplicate separate cost increase trends.

b. \_\_\_ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1. \_\_\_ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. \_\_\_ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i. \_\_\_ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.

For each change, please report the following:

A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_

B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_

C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_

D. \_\_\_ Other (please describe):

ii. \_\_\_ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. \_\_\_ Changes brought about by legal action (please describe):

- B. \_\_\_\_\_ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
- C. \_\_\_\_\_ Other (please describe):
- iii. \_\_\_\_\_ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
  - A. \_\_\_\_\_ Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years \_\_\_\_\_ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
  - B. \_\_\_\_\_ Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above \_\_\_\_\_.

\* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

- d. \_\_\_\_\_ **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
  - 1. \_\_\_\_\_ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: \_\_\_\_\_. Please provide documentation.
  - 2. \_\_\_\_\_ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
    - i. \_\_\_\_\_ State Plan Service trend
      - A. \_\_\_\_\_ Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above \_\_\_\_\_.
- e. \_\_\_\_\_ **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d**, then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.
  - 1. List the State Plan trend rate by MEG from **Section D.I.I.a.** \_\_\_\_\_

2. \_\_\_ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. \_\_\_ The State has not made an adjustment because the same copayments are collected in managed care and FFS.
4. \_\_\_ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. \_\_\_ No adjustment was necessary and no change is anticipated.
2. \_\_\_ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

*Method:*

1. \_\_\_ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. \_\_\_ Determine copayment adjustment based on pending SPA.
3. \_\_\_ Determine copayment adjustment based on currently approved copayment SPA.
4. \_\_\_ Other (please describe):

- i. **Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

*Basis and method:*

1. \_\_\_ No adjustment was necessary
2. \_\_\_ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. \_\_\_ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4. \_\_\_ The State made this adjustment:\*
  - i. \_\_\_ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix C5**.
  - ii. \_\_\_ Other (please describe):

- j. **Pharmacy Rebate Factor Adjustment :** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1. \_\_\_ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the

first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. \_\_\_ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. \_\_\_ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

**Special Note for initial combined waivers (Capitated and PCCM) only:**

**Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations** -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (\*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

- n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported. Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.  [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present.*)

2.  [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future.*)

i.  State historical cost increases. Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.  National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

**The Non-Emergency Transportation Waiver is funded for each fiscal year through a fixed contract amount at the level appropriated by the Florida Legislature. The contracting entity is allowed to submit biweekly invoice amounts for a specific State fiscal year and payments are made until that annual contracted amount is exhausted. The contracted amount is subject to revision as directed by the Florida Legislature or Governor. The historic costs identified for R1-R2 were the actual payments made to the contracting entity during waiver period R1 and for the first five months (April 2011-August 2011) of the waiver period R2.**

A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_

B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_

C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_

D. \_\_\_ Other (please describe): \_\_\_\_\_

ii. \_\_\_ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. \_\_\_ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain: \_\_\_\_\_

iv. \_\_\_ Changes brought about by legal action (please describe): \_\_\_\_\_

For each change, please report the following:

A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_

B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_

C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_

D. \_\_\_ Other (please describe): \_\_\_\_\_

v. \_\_\_ Changes in legislation (please describe): \_\_\_\_\_

For each change, please report the following:

A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_

B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_

C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_

D. \_\_\_ Other (please describe): Other (please describe): \_\_\_\_\_

A. \_\_\_ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment \_\_\_\_\_

B. \_\_\_ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment \_\_\_\_\_

C. \_\_\_ Determine adjustment based on currently approved SPA. PMPM size of adjustment \_\_\_\_\_

D. \_\_\_ Other (please describe): \_\_\_\_\_

E. \_\_\_

c. \_\_\_ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term*

from present into the future), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

- i. State historical 1915(b)(3) trend rates
  1. Please indicate the years on which the rates are based: base years \_\_\_\_\_
  2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):
- ii. State Plan Service Trend
  1. Please indicate the State Plan Service trend rate from **Section C.I.J.a.** above \_\_\_\_\_.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section C.I.J.a.** \_\_\_\_\_
2. List the Incentive trend rate by MEG if different from **Section C.I.J.a.** \_\_\_\_\_
3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)\*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1. \_\_\_\_\_ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population. Please account for this adjustment in **Appendix C5**.

**on the funding level appropriated for non-emergency transportation services by the Florida legislature.**

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix C7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section C.I.I and C.I.J**:

**(Not Applicable) There are no transportation service unit costs to the Medicaid program. All services costs are covered by the annual contract fixed budget amount.**

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix C7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section C.I.I and C.I.J**:

**Changes in service utilization do not directly impact this waiver's cost effectiveness. The contracting entity is responsible for providing all necessary services to the eligible population at the annual contract fixed budget cost.**

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix C7 Column I**.

**No additional factors.**

**Part II: Appendices C.1-7**

**Please see attached Excel spreadsheets.**