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September 3, 2021

Mr. Jack Nocito
Project Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Mr. Nocito:

Enclosed for your review is a request to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-002064). The request seeks to:

- Modify the Low-Income Pool (LIP) Special Terms and Conditions (STC) to include non-profit licensed behavioral health providers that participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers;
- Extend the postpartum coverage period from 60-days to 12-months following the last day of pregnancy; and
- Remove Special Terms and Conditions (STC) language requiring the State submit a continuance letter to CMS each year to continue the operation of the waiver of retroactive eligibility and the essential provider contracting requirement.

We appreciate your consideration of this request and your efforts in working with our staff on amending Florida's 1115 MMA Waiver. Should you have any questions, please contact Kimberly Quinn of my staff at (850) 412-4284. We look forward to continuing to work with you.

Sincerely,

[redacted]

Tom Wallace
Deputy Secretary for Medicaid

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Florida Managed Medical Assistance Waiver

1115 Research and Demonstration Waiver
Project Number 11-W-00206/4

Amendment Request:

Low-Income Pool
Postpartum Coverage
Retroactive Eligibility and Essential Provider Contracting
Language Revision

CMS Submission

September 3, 2021

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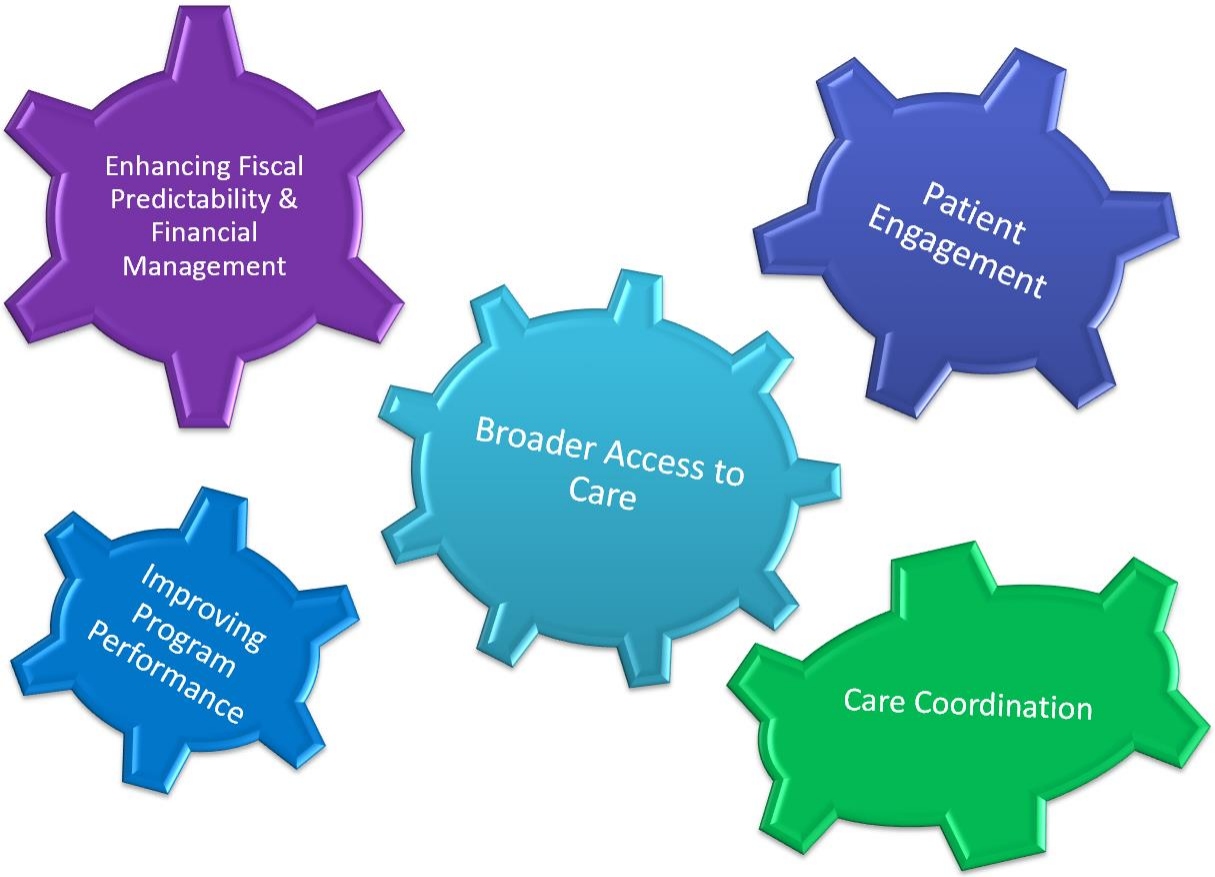
Introduction

The Managed Medical Assistance (MMA) program, operated under Florida Medicaid's 1115 MMA Waiver (Project Number 11-W-00206/4), 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 to:

- Modify the Low-Income Pool (LIP) Special Terms and Conditions (STC) to include non-profit licensed behavioral health providers that participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers.
- Extend the postpartum coverage period from 60 days to 12-months following the last day of pregnancy.
- Remove Special Terms and Conditions (STC) language requiring the State submit a continuance letter to CMS each year to continue the operation of the waiver of retroactive eligibility and the essential provider contracting requirement.

Goals and Objectives

The goals of the MMA Waiver are to promote an integrated health care delivery model that:

- Incentivizes quality and efficiency.
- Improves health outcomes through care coordination and recipient engagement in their own health care.
- Improves program performance, particularly improved scores on nationally recognized quality measures (such as Health Plan Effectiveness Data and Information Set).
- Improves access to coordinated care by enrolling all Medicaid recipients in MMA plans except those specifically exempted.
- Enhances access to primary and preventive care through robust provider networks.
- Enhances fiscal predictability and financial management by converting the purchase of Florida Medicaid services to capitated, risk-adjusted, payment systems. Strict financial oversight requirements are established for MMA plans to improve fiscal and program integrity.

Including non-profit licensed behavioral health providers who participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers eligible for LIP, will increase access to care.

Reducing movement in and out of Medicaid lowers average monthly per capita spending in Medicaid, increases utilization of preventive care, reduces the likelihood of inpatient hospital admissions and emergency room visits, and prevents disruption for enrollees, health plans, and providers. The churn from losing Medicaid coverage 60-days postpartum not only may result in unaddressed health conditions for mothers, but also more broadly impacts Medicaid in that the mothers will become eligible for Medicaid again if they become pregnant again, but with potentially increased long-term costs due to the impact of the mother's untreated conditions on her children, both born and unborn. Expanding the postpartum eligibility period ensures continuity of care and care coordination during the postpartum period and presents an incredible opportunity to enhance efforts around improving birth outcomes, which furthers the goals of the MMA Waiver and the Medicaid program.

Amendment and Waiver Overview

LIP Overview

Senate Bill 2500, passed by the Florida Legislature in 2021, added in the provision authorizing non-profit licensed behavioral health providers who participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers eligible to receive Low-Income Pool (LIP) funding.

Postpartum Overview

Senate Bill 2518, passed by the Florida Legislature in 2021, extends the postpartum eligibility coverage period from 60-days, as prescribed in the Social Security Act (SSA) and Code of Federal Regulations (CFR), to 12-months following the last day of pregnancy.

Through this amendment, the State is seeking to improve postpartum maternal morbidity and mortality in the state by extending access to quality care and by ensuring continuity of care and care coordination during the postpartum period. The postpartum extension is anticipated to result in lower average monthly per capita spending in Medicaid, increased utilization of preventive care, reduce the likelihood of inpatient hospital admissions and emergency room visits, and prevent disruption for enrollees, health plans, and providers. The waiver will allow the State to extend postpartum Medicaid coverage from 60-days to 12-months. The covered services and eligibility requirements will remain consistent with the existing services and eligibility requirements throughout the 12-month period.

Retroactive Eligibility and Essential Provider Contracting Language Revision

Senate Bill 2518, passed by the Florida Legislature in 2021, authorized the Agency to continue the waiver of retroactive eligibility and the essential provider contracting requirement without expiration. The State is thus requesting a revision of the language contained in Waiver Authority four and STC 19(b), regarding the waiver of retroactive eligibility, and STC 69 concerning the essential provider contracting requirement. The currently approved STCs require the Agency to submit a letter to CMS each year following the legislative session reauthorizing these provisions; however, since both of these provisions were extended indefinitely, the State is requesting the removal of this requirement.

MMA Waiver Historical Overview

The Florida Medicaid Reform demonstration was approved October 19, 2005. The state implemented the demonstration July 1, 2006, in Broward and Duval Counties, and then expanded to Baker, Clay, and Nassau Counties July 1, 2007. On December 15, 2011, CMS agreed to extend the demonstration through June 30, 2014.

The December 2011 renewal included several important improvements to the demonstration, such as enhanced managed care requirements to ensure increased stability among managed care plans, minimize plan turnover, and provide for an improved transition and continuity of care when enrollees change plans and to ensure adequate choice of providers. The renewal also included a Medical Loss Ratio (MLR) requirement of 85 percent for Medicaid operations. Finally, the renewal included the continuation of the LIP of $1 billion (TC) annually to assist safety net providers in providing health care services to Medicaid, underinsured and uninsured populations.

On June 14, 2013, CMS approved an amendment to the demonstration, which retains all of the improvements noted above, but allowed the state to extend an improved model of managed

care to all counties in Florida subject to approval of an implementation plan and a determination of readiness based on the elements of the approved plan. The amendment also changed the name of the demonstration to the Florida Managed Medical Assistance (MMA) program. CMS authorized implementation to begin no earlier than January 1, 2014, with the Medicaid Reform demonstration continuing to operate in the five Medicaid Reform counties until the MMA program was implemented there.

Under the June 2013 amended demonstration, most Medicaid eligibles were required to enroll in a managed care plan (either a capitated managed care plan or an FFS Provider Service Network (PSN)) as a condition for receiving Medicaid. Enrollment was mandatory for Temporary Assistance for Needy Families (TANF)-related populations and the aged and disabled, with some exceptions. The demonstration continued to allow plans to offer customized benefit packages and reduced cost sharing, although each plan must cover all mandatory services, and all state plan services for children and pregnant women (including Early and Periodic Screening, Diagnostic and Treatment (EPSDT)). The demonstration provided incentives for healthy behaviors by offering Enhanced Benefits Accounts that were replaced by the plan's Healthy Behaviors program upon implementation of the MMA program as described in STC 54.

Beneficiaries in counties transitioning from Medicaid Reform to MMA continued to have access to their accrued credits under Enhanced Benefit Account Program (EBAP) for one year.

The June 2013 amended terms and conditions included improvements such as:

- A phased implementation to ensure readiness including a readiness assessment for each region and a requirement for CMS approval of the state's implementation plan which will include identified risks, mitigation strategies, fail safes, stakeholder engagement and rapid cycle improvement strategies;
- Strengthened auto-enrollment criteria to ensure consideration of network capacity, access, continuity of care, and preservation of existing patient-provider relationships when enrolling all beneficiaries into the MMA program, including special populations;
- STCs tailored to special populations, should the state choose to include specialty plans in the final selection of managed care entities and PSNs;
- Strong consumer protections to ensure beneficiary assistance and continuity of care through the MMA transition. Additional STCs to ensure beneficiary choice, including a comprehensive outreach plan to educate and communicate with beneficiaries, providers, and stakeholders and annual Health Plan Report Cards for consumers, which will allow beneficiaries to be more informed on health plan performance and assist beneficiaries in making informed decisions related to plan selection;
- Enhanced Medical Care Advisory Committee (MCAC) requirements to ensure beneficiary and advocate group participation as well as inclusion of subpopulation advisory committees;
- Performance Improvement Projects (PIP) to be performed by all health plans;
- Clarification and enhancements of the monitoring and evaluation of plans to ensure a rigorous and independent evaluation, and development of rapid cycle, transparent monitoring in order to ensure continuous progress towards quality improvement; and,
- A Comprehensive Quality Strategy (CQS) that will span the entire Florida Medicaid program.

The approved 2014 extension of the demonstration continued the improvements authorized in the June 2013 amendment and extended all portions of this demonstration for three years, except for the Low-Income Pool (LIP). CMS authorized extension of the Low-Income Pool for one year, from July 1, 2014 through June 30, 2015.

- During the one-year extension for the LIP, expenditures were authorized to provide stability for providers for a limited time during Florida's transition to statewide Medicaid managed care and a significantly reformed Medicaid payment system. Funding sources were limited only to existing state and local funding arrangements. The total amount of LIP funding could not exceed $2,167,718,341 (TC).
- Florida was required to analyze and develop a plan to reform Medicaid provider payments and funding mechanisms, with the goal of developing sustainable, transparent, equitable, appropriate, accountable, and actuarially sound Medicaid payment systems and funding mechanisms that ensure quality health care services to Florida's Medicaid beneficiaries throughout the state without the need for LIP funding. Expenditures authorized under the LIP were limited to UC costs of providers, the independent report discussed below, and other categories of expenditure as specified in the STCs.
- UC costs were required to be verified through provider cost reports. CMS indicated that it would disallow unallowable payments to providers in prior DYs as identified on provider cost reports.
- During the one-year LIP extension, the state was required to use a portion of the LIP funds to commission a report from an independent entity on Medicaid provider payment in the state that reviews the adequacy of payment levels, and the adequacy, equity, accountability and sustainability of the State's funding mechanisms for these payments. The report was required to recommend reforms to the Florida Medicaid financing system that can allow the state, beginning in state fiscal year (SFY) 2015-2016, to move toward Medicaid FFS and managed care payments that ensure access for Medicaid beneficiaries to providers without payments through the LIP. The final report was due no later than March 1, 2015.

On June 30, 2015, pursuant to a letter to the state, CMS granted 60 days of interim expenditure authority under section 1115(a)(2) of the Social Security Act, to make federal funding available to Florida for interim LIP payments to providers from July 1, 2015 through August 31, 2015 of DY (DY) 10, subject to a total spending limit of $166. 66 million for the combined federal and state shares of expenditures (with such amount being counted in determining the amount of any further extension of the Low-Income Pool).

On October 15, 2015, CMS approved three amendments to the demonstration.

- The first amendment added two populations as voluntary enrollees in managed care: Medicaid-eligible children receiving Prescribed Pediatric Extended Care (PPEC) services, and recipients residing in group home facilities licensed under section(s) 393. 067 Florida Statutes (FS).
- The second amendment authorized changes to managed care enrollment to auto-assign individuals into managed care during a plan choice period immediately after eligibility determination. The amendment also changes the auto-assignment criteria. Individuals will receive both their managed care plan assignment and information about choice of plans in their area. Individuals may actively select a plan during a 120-day change/disenrollment period post-enrollment.

- The third amendment authorized expenditures under the LIP through June 30, 2017. The total amount of LIP funding in DY 10 (July 1, 2015 – June 30, 2016) will not exceed $1 billion (TC). The total amount of LIP funding in DY 11 (July 1, 2016 – June 30, 2017) will not exceed $607,825,452 million (TC). The changes represent a transition to a LIP that reflects the cost to providers of UC for uninsured individuals in the state, and that no longer pays for care that may be or has been provided through available coverage options. The changes set Florida on a path to administering a LIP in 2016-2017 (DY 11) that distributes funds based on the burden placed on providers by services for low-income, uninsured individuals for whom no other coverage options are, or could be, made available.

On October 12, 2016, CMS approved three amendments, which modified the demonstration to: (a) allow Florida flexibility to contract with one to three vendors under the hemophilia program; (b) Include payments for nursing facility (NF) services in MMA capitation rates for recipients under the age of 18 years; and (c) allow flexibility for specialty plans to conduct Performance Improvement Projects (PIP) on topics that have more specific impacts to their enrollees, with Florida approval.

Under the demonstration, Florida seeks to continue building on the following objectives:

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top quality scores, and high rate of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.
- Improving program performance, particularly improved scores on nationally recognized quality measures (such as HEDIS scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care by enrolling all Medicaid enrollees in managed care except those specifically exempted due to short-term eligibility, limited-service eligibility, or institutional placement (other than nursing home care).
- Increasing access to, stabilizing, and strengthening providers that serve uninsured, low-income populations in the state by targeting LIP funding to reimburse UC costs for services provided to low-income uninsured patients at hospitals that are furnished through charity care programs that adhere to the (HFMA) principles.

On August 1, 2017, CMS reauthorized the MMA Medicaid managed care program for the 5-year extension without significant changes to the program. The revised STCs for the extension reflected the state's obligation to follow the Medicaid managed care regulations at 42 CFR 438, and CMS and Florida agreed to several revisions to the STCs that previously governed the state's LIP. The revised LIP calculations reflected in the extension STCs led to a new TC annual LIP limit of $1.5 billion per DY—which was an annual increase of approximately $900 million compared to the previous DY's LIP amount.

There were two changes which led to the increased annual LIP limit:

- CMS' analysis of more recent Florida hospital cost report data led to an increase of $450

million in annual LIP; and

- CMS did not apply the previous LIP reduction for Medicaid expansion which led to an additional increase of $450 million annually—this was the only significant change to CMS' previous methodology for determining UC amounts.

Consistent with CMS' goal of lessening or removing unduly burdensome and/or duplicative state reporting requirements, where appropriate, the extension STCs also omitted the requirement for quarterly reporting on all MMA demonstration activities (although expenditures continue to be reported quarterly, and annual reporting is required, consistent with the statutory requirement of periodic state reports). In addition, the requirement for the state to submit the LIP Reimbursement and Funding Methodology (RFMD) document for the first extension DY—with subsequent annual attestations that the methodology remains in effect. CMS also eliminated the requirement for a Comprehensive Quality Strategy in the extension; however, the state still is required to develop and maintain a managed care quality strategy as required under 42 CFR §438. 340.

On December 20, 2017, the Agency received federal approval to:

- Transition the federal authority to serve individuals enrolled in the MEDS-AD section 1115 demonstration to MMA; and
- Establish financial and non-financial eligibility criteria for individuals diagnosed with Acquired Immune Deficiency Syndrome (AIDS) to obtain and maintain coverage for Medicaid benefits without the need for enrollment in the 1915(c) Project AIDS Care (PAC) waiver.

On November 30, 2018, the Agency received federal approval to:

- Modify the Low-Income Pool Special Terms and Conditions to add:
    - Regional Perinatal Intensive Care Centers as an eligible hospital ownership subgroup effective State Fiscal Year (SFY) 2017/18.
    - Community behavioral health providers as a participating provider group effective SFY 2018/19.
- Eliminate the three-month Medicaid retroactive eligibility period for non-pregnant recipients aged 21 years and older (adults) effective July 1, 2018. Eligibility will continue to begin the first day of the month in which a non-pregnant adult applies for Florida Medicaid.
- Operate a Statewide Medicaid prepaid dental health program (PDHP). The PDHP will operate as an "Additional Program" under Section XIII of the Special Terms and Conditions in order to provide Florida Medicaid State Plan dental services to recipients through dental managed care organizations (dental plans). The PDHP is expected be implemented by January 1, 2019.
    - The PDHP did not reduce, or otherwise impede access to, Florida Medicaid dental services for any impacted recipient. The State is not requesting any substantive changes to the 1115 MMA Waiver outside those specified in this amendment request. The State anticipates the PDHP will operate in accordance with the existing CMS-approved Special Terms and Conditions to the extent applicable. Any areas of divergence are specified in the amendment request.

On March 26, 2019, an amendment was approved to the demonstration to implement a pilot

program that provides additional behavioral health services and supportive housing assistance services for persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, who are homeless or at risk of homelessness due to their disability. The pilot program will be operated in two regions of the State, Regions 5 (Pasco and Pinellas counties) and Region 7 (Brevard, Orange, Osceola and Seminole counties).

On April 7, 2020, the Agency received federal approval to:

- Raise the Behavioral Health and Supportive Housing Assistance Services Pilot's annual enrollment limit from 42,500 member months to 50,000 member months each demonstration year.
- Revise the state's LIP program by incorporating additional specific tiering criteria within the FQHC/RHC group.
- Increase the capped annual allotment for the FQHC/RHC group to $75,000,000, a $25,000,000 increase.

In July 2020, the State of Florida submitted an extension request for the 1115 MMA Waiver. The request did not include any amendments to the waiver design or the approved STCs, except STC 71 (LIP) to align with updates in Florida law.

CMS approved the State's ten-year extension request on January 15, 2021 and the Agency accepted the STCs, issued by CMS, with technical edits on January 19, 2021.

Effect on Recipients

LIP Amendment

Modifying STC 69(d) to include non-profit licensed behavioral health providers who participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers eligible to receive LIP funding will expand access to care and will not have an adverse impact on recipients.

Postpartum Coverage Extension

The maternal mortality rate in the United States has doubled over the past two decades, and the United States is the only developed nation with an increasing maternal mortality rate.[1] The United States maternal mortality rate was 17.4 per 100,000 births in 2018.[2] In contrast, Florida's maternal mortality rate for the same period was 18.06 per 100,000 births.[3] According to the federal Centers for Disease Control and Prevention (CDC), the rate of maternal mortality in the United States also includes vast disparities between racial and ethnic groups, with

[1] Mayer R, Dingwall A, Simon-Thomas J, et al. (2019, February 4) The United States Maternal Mortality Rate Will Continue To Increase Without Access To Data, Health Affairs Blog, Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20190130.92512/full/

[2] Declercq, Eugene and Zephyrin, Laurie (2020, December). Maternal Mortality in the United States. The Commonwealth Fund: Advancing Health Equity. https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer

[3] Florida Department of Health, Bureau of Vital Statistics. (2021, July). Florida Maternal Mortality Report. Retrieved from http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=InfantDeath.TenYrsRpt

pregnancy-related mortality ratios more than three times higher for non-Hispanic black women than non-Hispanic white women from 2011-2016.[4] The CDC, which defines the full postpartum period as 12-months after delivery, also has found that 60% of pregnancy-related deaths occurring up to one year after delivery are preventable.

Continuity of Care for Medical and Behavioral Health Services During the Postpartum Period

The American Society of Addiction Medicine notes that the first year after delivery is stressful and, due to stress being a relapse risk factor, women are at an increased risk of relapse and overdose during this time.[5] Additionally, according to an American Academy of Pediatricians (AAP) 2010 clinical report, perinatal depression is the most under-diagnosed obstetric complication in America, as many as 12% of all pregnant or postpartum women experience depression in a given year, and for low-income women, the prevalence is doubled. The AAP clinical report also notes that the peeks for depression are six weeks after birth of a child for major depression, two to three months after birth for minor depression, and six months after birth of a child. [6]

The American College of Obstetricians and Gynecologists (ACOG) cited additional examples of challenges created by Medicaid coverage ending 60-days postpartum. The examples of challenges for their patients include: patients with cardiomyopathy, which is caused by pregnancy, needing close follow-up with a cardiologist to monitor heart function and manage medications postpartum, patients not having coverage when they are in need of mental health services, patients who began treatment prior to 60-days postpartum needing six weeks of monitoring to determine if anti-depressant drugs are effective, and patients who request tubal ligation for permanent contraception not being able to receive the service due to scheduling challenges between the postpartum follow-up appointment and the end of the 60-day postpartum coverage window, and patients needing access to all forms of postpartum contraception, which are critical for birth spacing and preventing undesired pregnancies within the following year as closely timed pregnancies are associated with preterm birth and placental abruption.

Switching coverage at 60-days postpartum also adds new risks onto an already medically vulnerable time. For example, it may: require a new mother to switch from providers who have an understanding of her health history to providers she does not already have an established or trusted relationship with during a medically vulnerable time due to different health plan provider networks; create gaps in coverage from switching health plans (a 2019 Health Affairs article on

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[4] Centers for Disease Control and Prevention. (2019, October 10). Pregnancy Mortality Surveillance System. Retrieved https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpregnancy-mortality-surveillance-system.htm

[5] American Society of Addition Medicine. (2017, January). Public Policy Statements: Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids. Retrieved from https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policystatements/2017/01/19/substance-use-misuse-and-use-disorders-during-and-following-pregnancy-with-anemphasis-on-opioids

[6] American Academy of Pediatricians. (2010, October). Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice. Retrieved from https://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf

perinatal insurance churn notes that 57.4% of insurance disruptions included a period of un-insurance[7]); result in coverage loss for mothers who do not having the capacity or resources to seek out alternative coverage; and result in missed treatments for follow-up appointments due to coverage gaps or loss. A 2013 Health Affairs article notes that even brief gaps in coverage can lead otherwise preventable or treatable health problems, such as asthma, diabetes, and behavioral disorders, resulting in costly hospital admissions and emergency department visits.[8] Additionally, a March 2014 Medicaid and CHIP Payment and Access Commission (MACPAC) report noted that reducing movement in and out of Medicaid lowers average monthly per capita spending in Medicaid, increases utilization of preventive care, reduces the likelihood of inpatient hospital admissions and emergency room visits, and prevents disruption for enrollees, health plans, and providers.[9] The churn from losing Medicaid coverage 60-days postpartum not only may result in unaddressed health conditions for mothers, but also more broadly impacts Medicaid in that the mothers will become eligible for Medicaid again if they become pregnant again and their children remain covered through CHIP, which has a higher income threshold, but with potentially increased long-term costs due to the impact of the mother's untreated conditions on her children.

Mother's Health Has a Direct Impact to the Health of Children

A mother's health and well-being have significant impacts on the health of her children. Research shows that when adults have coverage, their children are more likely to access preventive care.[10] A study published in Pediatrics in 2017 found that parental enrollment in Medicaid was associated with a 29 percentage point higher probability that their child received an annual well-child visit; children who receive well-child visits are more likely to complete immunization schedules and are less likely to have avoidable hospitalizations.[11] Well-child visits occur more frequently for infants and are also used to engage caregivers about parenting and healthy development as well as identify parent or family circumstances, such as parental depression which can negatively affect a child's trajectory if unaddressed.[12]

An AAP 2010 clinical report notes that postpartum depression leads to increased costs of medical care, inappropriate medical care, child abuse and neglect, discontinuation of

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[7] Daw, J.R., Backes Kozhimannil K., Admon, L.K.. (2019, September). High Rates of Perinatal Insurance Churn Persist After The ACA. Health Affairs Blog. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20190913.387157/full/

[8] Ku, L., Steinmetz, E., Bruen, B. (2013, September), Continuous-Eligibility Policies Stabilize Medicaid Coverage For Children And Could Be Extended To Adults With Similar Results, Health Affairs, Vol. 32., No. 9: Navigating the Thorns that Await the ACA. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0362

[9] Medicaid and CHIP Payment and Access Commission. (2014, March) Report to the Congress on Medicaid and CHIP Chapter 2: Promoting Continuity of Medicaid Coverage among Adults under Age 65. Retrieved from https://www.macpac.gov/wpcontent/uploads/2015/01/Promoting_Continuity_of_Medicaid_Coverage_among_Adults_under_65.pdf

[10] Wright Burak, El, Clark, M. Roygardner, L. (2019, December). Nation's Youngest Children Lose Health Coverage at an Alarming Rate. Georgetown University Health Policy Institute Center for Children and Families. https://ccf.georgetown.edu/wp-content/uploads/2019/12/Uninsured-Kids-under-6-final-1.pdf

[11] Retrieved from https://pediatrics.aappublications.org/content/pediatrics/140/6/e20170953.full.pdf

[12] https://ccf.georgetown.edu/wp-content/uploads/2019/12/Uninsured-Kids-under-6-final-1.pdf

breastfeeding, and family dysfunction and adversely affects early brain development.[13] A Georgetown University Health Policy Institute Center for Children and Families paper notes that the neural networks that enable children's brains to take in vast amounts of information also make them especially vulnerable.[14] For example, the AAP report notes that as early as two months of age, an infant of a depressed mother will look at the mother less often, shows less engagement with objects, have a lower activity level, and have poor state regulation, with developmental and attachment issues not only persisting, but being less likely to respond to interventions over time. Research also has found that parents who live with temporary or chronic health challenges have limited resources for childrearing, which can lead to increased stress and add to other adverse childhood experiences (ACEs) that negatively impact a child's life trajectory. ACEs are linked to an increased risk for physical and mental health problems, poorer school readiness and educational outcomes, and involvement with the juvenile justice system; stressors on parents, including financial, mental health, substance use, and other health conditions prevent them from fully responding to their own health needs as well as their children's health needs, which then impedes their children's development.[15] While the AAP 2010 clinical report notes that treating a mother's depression also is associated with improvement of depression and other disorders in her child,[16] a multi-site, multi-year review of postpartum depression found that because of the 60-day postpartum limit on Medicaid benefits, many screened mothers were not able to access the postpartum depression care.[17] Research on the impact of the mother not accessing care for mental health, substance use, and other medical conditions demonstrate the need for systemic changes to increase affordable access to medically appropriate care.

Birth Outcomes Initiatives and Stakeholder Engagement

The Agency's current birth outcomes initiatives aim to ensure quality care and safety for mothers and babies, with the overarching goal of lowering maternal and infant morbidity and mortality rates. Each health plan's contract includes targeted and measurable goals to reduce primary caesarean section, pre-term delivery, and neonatal abstinence syndrome (NAS) rates among Medicaid members.

The Agency and contracted health plans are continuously implementing evidence-based strategies and promising practices to improve perinatal, maternal, and child health.

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[13] American Academy of Pediatricians. (2010, October). Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice. Retrieved from https://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf

[14] Wright Burak, E. and Rolfes-Haase, K., (2018, November). Using Medicaid to Ensure the Healthy Social and Emotional Development of Infants and Toddlers. Retrieved from https://ccf.georgetown.edu/wpcontent/uploads/2018/12/Medicaid-and-IECMH_FINAL.pdf

[15] Wright Burak, E. and Rolfes-Haase, K., (2018, November). Using Medicaid to Ensure the Healthy Social and Emotional Development of Infants and Toddlers. Retrieved from https://ccf.georgetown.edu/wpcontent/uploads/2018/12/Medicaid-and-IECMH_FINAL.pdf

[16] American Academy of Pediatricians. (2010, October). Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice. Retrieved from https://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf

[17] Bobo, WV, Wollan P., Lewis G., Bertram S., Kurland, M.J., Vore, K., Yawn, B.P. (2014, September). Depressive symptoms and access to mental health care in women screened for postpartum depression who lose health insurance coverage after delivery: findings from the Translating Research into Practice for Postpartum Depression (TRIPPD) effectiveness study, Mayo Clinic Proc. Vol 89, No. 9: 1220-8. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/25091871

In addition to contracted commitments from the plans, the Agency convenes monthly stakeholder workgroups to identify evidence-based strategies and potential solutions to improve birth outcomes through collective impact. Through extensive stakeholder engagement with physicians, health plans, other state agencies, hospitals, community organizations, the Florida Perinatal Quality Collaborative, and various associations, the Agency has identified a variety of strategies for improving birth outcomes. The Agency has been working diligently to reduce barriers to accessing care, such as adopting Substance Abuse and Mental Health Services Administration guidelines for screening, brief intervention, and referral to treatment (SBIRT) billing, CDC guidelines for prior authorization requirements regarding buprenorphine prescribing for greater ease to access MAT for Medicaid eligible women of childbearing age and configuring systems to allow doulas the opportunity to bill as a Medicaid provider.

Extending postpartum care for mothers eligible for Medicaid to a period of 12-months after delivery, provides the Agency and the workgroup with an incredible opportunity to enhance efforts around improving birth outcomes. Existing partnerships and forums position the Agency to better address postpartum health among Medicaid mothers. Over the coming months, the Agency will be conducting extensive evidence-based research to develop and incorporate additional birth outcomes initiatives relating to postpartum care, mental health, and maternal mortality.

Based on data and research nationally, the State must take systemic action to improve outcomes for women during the postpartum period. However, the current federal policy that ends categorical eligibility for pregnant women 60-days postpartum limits the State's ability to leverage its Medicaid managed care infrastructure to strategically address the State's maternal morbidity and mortality crisis through the care coordination and performance improvement reporting by the Medicaid managed care plans. Through CMS' approval of the postpartum extension, the maternal morbidity and mortality in the State will be improved by extending access to quality care and by ensuring continuity of care and care coordination during the 12-month postpartum period.

Retroactive Eligibility and Essential Provider Contracting Language Revision

Eliminating the requirement for the Agency to submit to CMS a continuance letter each year, following the legislative session for the waiver of retroactive eligibility and the essential provider contracting requirement, will have no impact on recipients or providers. Both provisions have been in place and will continue to operate within the establish parameters.

Federal Waiver and Expenditure Authorities

LIP

The Agency is not requesting any changes to the waiver authorities or expenditure authorities as authorized on January 19, 2021, for the inclusion of non-profit licensed behavioral health providers that participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers.

The Agency is seeking an amendment to STC 69(d) to authorize this provider type under community and behavior health providers:

69. LIP Provider Participation Requirements

d. Community Behavioral Health Providers

i. Community Behavioral Health providers are providers in the substance abuse and mental health safety net system (Central Receiving Systems) administered by the Florida Department of Children and Families. A Central Receiving System consists of a designated central receiving facility and other service providers that serve as a single point or a coordinated system of entry for individuals needing evaluation or stabilization under section 394.463 or section 397.675, Florida Statutes, or crisis services as defined in section 394.67, Florida Statutes.

ii. Non-profit licensed behavioral health providers that participate in the coordinated system of care in counties that have implemented indigent care programs.

iii. Community Behavioral Health providers is a LIP provider category effective as of December 1, 2018.

iv. Must be enrolled in Medicaid.

Postpartum Extension

The State is requesting the authority to extend postpartum Medicaid coverage from 60-days to 12-months. To accomplish this, the State is requesting the following waiver authorities:

- 42 CFR 435.4, in order to define pregnant women through 12-months postpartum instead of 60 days postpartum;
- 42 CFR 435.170, to extend eligibility for pregnant women from 60-days to 12-months postpartum, extend continuous eligibility for pregnant women from 60-days to 12-months postpartum; and
- 42 CFR 435.916(a), to extend the renewal of MAGI-based income to the end of the 12-month postpartum period.

Retroactive Eligibility and Essential Provider Contracting Language Revision

The State is requesting an amendment to Waiver Authority four: Retroactive Eligibility. The State proposes eliminating the requirement to submit a letter each year to CMS regarding legislative approval to continue the waiver of retroactive eligibility, as during the 2021 legislative session, the Agency was granted the authority to continue this provision without expiration.

4. Retroactive Eligibility Section **1902(a)(34)**

Effective February 1, 2019, to enable Florida to only provide medical assistance beginning the month in which a beneficiary's Medicaid application is filed, for adult beneficiaries who are not pregnant or within the 60-day period after the last day of the pregnancy, and are aged 21 and older. The waiver of retroactive eligibility does not apply to pregnant women (or during the 60- day period beginning on the last day of the pregnancy), infants under one year of age, or individuals under age 21. ~~Annually, 60 days after the state legislative process has concluded, the state must submit a letter to CMS indicating Florida legislative approval. Absent this documentation the waiver of retroactive eligibility will be suspended until such time the letter is provided to CMS.~~

Similarly, the State is requesting this requirement be stricken in STC 19(b):

19. Waiver of Retroactive Eligibility Population. The state will not provide medical assistance for any month prior to the month in which a beneficiary's Medicaid application is filed, except for a pregnant woman (including during the 60-day period beginning on the last day of the pregnancy), or a beneficiary under age 21. The waiver of retroactive eligibility applies to all recipients aged 21 and older who are not pregnant or in the 60-day period after the last day of the pregnancy (non-pregnant adults), effective February 1, 2019. The waiver applies to non-pregnant adults who are eligible for Medicaid under the state plan (including all modified adjusted gross income (MAGI) and Non-MAGI related groups), as well as the MEDS AD Eligibility Group defined in STC 17 and the AIDS CNOM Eligibility Group defined in STC 18.

a. The state assures that it will provide outreach and education about how to apply for and receive Medicaid coverage to the public and to Medicaid providers, particularly those who serve vulnerable populations that may be impacted by the retroactive eligibility waiver.

~~b. The state currently has state legislative authority for this waiver through June 30, 2021. In the event the state legislature does not authorize the state to continue the waiver of retroactive eligibility or the state does not timely submit a letter to CMS, the~~ authority for the waiver of retroactive eligibility will end.

Additionally, the State is requesting an amendment to STC 69: LIP Provider Participation Requirements. The State proposes eliminating the requirement to submit a letter each year to CMS regarding legislative approval to continue the essential provider contracting requirement, as during the 2021 legislative session, the Agency was granted the authority to continue this provision without expiration.

69. LIP Provider Participation Requirements. In addition to any other applicable requirements, to be eligible for LIP funding, essential providers must offer to contract with each managed care plan in the state and must make a good faith effort to enter into a network contract with each statewide Medicaid managed care (SMMC) plan and each SMMC specialty plan. "Essential providers" are defined as faculty plans of Florida medical schools and hospitals licensed as specialty children's hospitals. If the state determines that an essential provider has not offered and negotiated in good faith to enter into a network contract with each managed care plan, then the state will notify the essential provider at least 90 days in advance of the start of the third quarter of the state fiscal year that LIP payments will not be made to the essential provider beginning with the third quarter of the state fiscal year and informing the essential provider how it may

avail itself of hearing rights. ~~Annually, 60 days after the state legislative process has concluded, the state must submit a letter to CMS indicating Florida legislative approval. The essential provider contracting requirement will be suspended should the Florida legislature no longer require this participation requirement as indicated in the letter submitted to CMS.~~

Evaluation Design

The evaluation of the demonstration is an ongoing process conducted during the life of the demonstration. The purpose of evaluating demonstration components is to ensure that all of the programs authorized under the demonstration are operating successfully and to identify areas for improvement. Evaluation reports are required under the Code of Federal Regulations as well as the STCs of the waiver.

Amendment Change	Impact on Evaluation Design
Modify the Low-Income Pool (LIP) Special Terms and Conditions (STC) to include non-profit licensed behavioral health providers that participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers.	The data components of the evaluation design will expand in the next demonstration year to include non-profit licensed behavioral health providers that receive LIP funding. The expansion of the data components will not have an impact on the evaluation design and will be covered under Component 4: The impact of LIP funding on hospital charity care programs. There is no hypothesis provided for the associated research question 4F since the research question is descriptive and provided for context (e.g., types of services provided by provider type).
Extend the postpartum coverage period from 60 days to 12-months following the last day of pregnancy.	In terms of the expansion of coverage for postpartum women from 60 days to 12 months, the main effect will be the addition of these women to the Medicaid program for 10 more months before they then presumably lose their Medicaid coverage. Although the change could potentially improve HEDIS measure results for Timeliness of Postpartum Care, the Agency has confirmed with its MMA evaluators that since the change in policy does not impact how the evaluation is conducted, there is not any reason to change the MMA evaluation design or hypotheses.
Remove Special Terms and Conditions (STC) language requiring the State submit a continuance letter to CMS each year to continue the operation of the waiver of retroactive eligibility and the essential provider contracting requirement.	Since this amendment change is administrative in nature, it will not have an impact on the evaluation design.

The changes in the amendment will not impact the current evaluation of the MMA Waiver. The State will not be modifying the evaluation design based on this amendment.

Budget Neutrality

The Agency is required to provide financial data demonstrating the detailed and aggregate, historical and project budget neutrality status for the requested waiver amendment period and cumulatively over the lifetime of the waiver. The Agency is also required to provide up-to-date responses to the Federal CMS Financial Management standard questions. The following addresses the items specified above and documents that the waiver continues to remain budget neutral.

General Budget Neutrality Requirements

A requirement of any 1115 Research and Demonstration Waiver is that the program must meet a budget neutrality test and provide documentation that the demonstration did not cost the program more than would have been experienced without the waiver. In addition, prior to an extension of the waiver, a projection and extension of new budget neutrality benchmarks using rebased trends must be provided for the requested waiver extension period.

To comply with the STCs of the waiver, the Agency must pass the budget neutrality "test", as well as provide quarterly reporting of the expenditures and member months for the waiver, which is used to monitor the budget neutrality. Florida's Research and Demonstration Waiver is budget neutral and is in compliance with all STCs specific to budget neutrality.

Budget Neutrality Results to Date

Table 11 located on the following page provides cumulative expenditures and case months for the reporting period for each demonstration year. The combined Per Member per Month (PMPM) is calculated by weighting Medicaid Eligibility Groups (MEGs) 1 and 2 using the actual case months. In addition, the PMPM targets as provided in the STCs are also weighted using the actual case months. Since inception of the demonstration through Demonstration Year 14, expenditures have been $29.5 billion less than the authorized budget neutrality limit. However, during last approved extension Florida savings were phased down; rebasing without waiver baseline and the new cumulative variance through Year 14 is $17.8 billion. As a result, the state remains in substantial compliance with budget neutrality and anticipates that by the end of the demonstration, the amount below the authorized budget neutrality limit will be even greater. Details for each year are provided on the following page.

Table 11 MEG 1 and 2 Cumulative Statistics					
DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PMPM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PMPM
Meg 1 & 2	17,863,960	$4,909,251,774	$710,757,766	$5,620,009,540	$314.60
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(683,841,416)	
% Of WOW					89.15%
DY 03	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PMPM
Meg 1 & 2	20,344,582	$5,509,817,851	$782,189,441	$6,292,007,292	$309.25
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,282,012,059)	
% Of WOW					83.07%
DY 04	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PMPM
Meg 1 & 2	23,390,983	$6,058,520,103	$902,006,202	$6,960,526,306	$297.57
WOW	23,390,983			$9,046,759,079	$386.76
Difference				$(2,086,232,774)	
% Of WOW					76.94%
DY 05	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PMPM
Meg 1 & 2	25,185,957	$6,473,151,442	$988,601,293	$7,461,752,734	$296.27
WOW	25,185,957			$10,402,975,168	$413.05
Difference				$(2,941,222,434)	
% Of WOW					71.73%
DY 06	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PMPM
Meg 1 & 2	26,610,064	$6,929,318,089	$1,148,641,394	$8,077,959,483	$303.57
WOW	26,610,064			$11,517,211,082	$432.81
Difference				$(3,439,251,599)	
% Of WOW					70.14%
DY 07	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PMPM
Meg 1 & 2	28,179,336	$7,224,274,901	$1,406,961,008	$8,631,235,909	$306.30
WOW	28,179,336			$12,789,222,314	$453.85
Difference				$(4,157,986,405)	
% Of WOW					67.49%
DY 08	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PMPM
Meg 1 & 2	28,867,69	$7,198,209,036	$1,579,606,142	$8,777,815,179	$304.07
WOW	28,867,69			$13,874,528,641	$480.62
Difference				$(5,096,713,462)	
% Of WOW					63.27%

DY 09	Actual MM	Total	PMPM
Meg 1 & 2	31,356,180	$10,347,813,344	$330.01
WOW	31,356,180	$12,802,876,677	$408.30
Difference		$2,455,063,333	
% Of WOW			80.82%
DY 10	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	35,298,667	$12,559,757,972	$355.81
WOW	35,298,667	$14,945,809,651	$423.41
Difference		$2,386,051,679	
% Of WOW			84.04%
DY 11	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	37,869,608	$12,617,825,845	$333.81
WOW	37,869,608	$16,195,633,698	$427.67
Difference		$3,577,807,853	
% Of WOW			77.91%
DY 12	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	35,150,221	$13,842,405,019	$393.81
WOW	35,150,221	$14,383,790,714	$409.21
Difference		$541,385,695	
% Of WOW			96.24%
DY 13	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	34,070,646	$14,165,379,691	$415.76
WOW	34,070,646	$14,584,834,792	$428.08
Difference		$419,455,101	
% Of WOW			97.12%
DY 14	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	33,801,497	$14,117,725,754	$417.67
WOW	33,801,497	$15,065,022,271	$445.69
Difference		$947,296,517	
% Of WOW			93.71%

The accompanying Excel files provides the required 1115 waiver templates supporting the waiver's compliance with the budget neutrality STCs.

Updates to member months and projections commencing with DY16 (SFY 21/22) incorporate additional costs to account for the postpartum eligibility extension for an additional 10 months to an average of 140,000 enrollees per year with an average cost of $1,900.00 per member per month.

Public Notice Process

Requirement: Documentation of the State's compliance with the public notice process set forth in §431.408 of this subpart, including the post-award public input process described in §431.420(c) of this subpart, with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration amendment application.

Public Comment Period

The Agency conducted the 30-day public comment period from July 26, 2021 through August 24, 2021.

The Agency notified stakeholders of the public comment period to solicit their input on the waiver amendment request using the following methods:

- Published a public notice on July 26, 2021 in the Florida Administrative Register, in compliance with Chapter 120, Florida Statutes.
- Emailed information on the proposed amendment as well as notice of the public comment period and meeting to individuals and organizations on the interested stakeholders list.
- Posted a prominent link on the Agency's website to the public notice materials: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

Consultation with Indian Health Programs

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

The Agency did not receive comments from either of the tribes.

Public Meetings

The public meeting occurred in-person and via webinar, during which the Agency provided an overview of the MMA program, a brief history of the MMA Waiver, a description of the amendment request, and allowed time for public comment. The summary of public comments received by the Agency is contained in the subsequent section of this document.

Pursuant to the provisions of the Americans with Disabilities Act, any person who required special accommodations to participate in the workshop/meeting, were advised to contact the Agency within at least seven days prior the workshop/meeting. The contact person and information provided was Karen Williams to be contacted via email at Karen.Williams@ahca.myflorida.com.

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

Schedule of Public Meetings		
Location	**Date**	**Time**
Webinar https://attendee.gotowebinar.com/register/4649340309447809547	August 9, 2021	11:00 a.m. – 12:00 p.m.
In-Person Meeting 2727 Mahan Dr. Building 3 Tallahassee, FL, 32308	August 9, 2021	11:00 a.m. – 12:00 p.m.

Submission of Written Comments

Written comments on the comprehensive waiver amendment request, were requested to be submitted to the Agency, during the public comment period as follows:

Mail: 1115 MMA Waiver Comprehensive Amendment Request
Bureau of Medicaid Policy
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Email: FLMedicaidWaivers@ahca.myflorida.com

Summary of Comments Received by the Agency

The following summarizes the public comments received during the 30-day comment period that began July 26, 2021 and ended August 24, 2021. The State addressed comments that were received during the public meeting and considered all comments received in preparing the amendment request.

Subject	Public Comment/Questions
Low-Income Pool	A comment regarding opening the Low-Income Pool to additional, for-profit, providers was received by the Agency.
Continuance Letter	There were no comments received by the Agency on the removal of the continuance letter language; however, there were several comments expressing concerns about the waiver of retroactive eligibility and the potential negative impacts to prospective Medicaid recipients.
Postpartum Extension	All comments received by the Agency covering the requested postpartum extension were supportive of this policy change. However, the Agency received comments regarding the pursuit of an 1115 Waiver Amendment as opposed to implementing this policy under the state plan option authorized through the American Rescue Plan Act.

Attachment I
Tribal Notification

Miccosukee Tribe of Florida – Disseminated via Email on July 23, 2021

Ms. Osceola:

This email is to notify the Miccosukee Tribe of Florida that the State of Florida is seeking federal authority to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) to extend the postpartum coverage period to 12-months, incorporate a new qualifying provider type under LIP, and to remove obsolete language.

The proposed amendment seeks to:

- Extend the postpartum coverage period from 60-days to 12-months,
- Authorize non-profit licensed behavioral health providers who participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers eligible to receive LIP funding; and
- Remove the requirement for the State to submit a continuance letter to CMS to continue the operation of the waiver of retroactive eligibility and the essential provider contracting requirement.

A full description of the proposed amendment request is located on the Agency for Health Care Administrations (Agency's) website at the following link: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the amendment request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from July 26, 2021 to August 24, 2021. The Agency has scheduled a public meeting to solicit meaningful input on the proposed waiver amendment from the public. The meeting will be held:

- Webinar: August 9, 2021, 11:00 a.m. – 12:00 p.m. To participate, register via the following link: https://attendee.gotowebinar.com/register/4649340309447809547

If you have any questions about this amendment or would like to hold a call, please contact me by August 24, 2021 via email at Karen.Williams@ahca.myflorida.com.

Sincerely,

Karen Williams

GOVERNMENT OPERATIONS CONSULTANT III

Seminole Tribe of Florida – Disseminated via Email on July 23, 2021

Dr. Kiswani-Barley:

This email is to notify the Seminole Tribe of Florida that the State of Florida is seeking federal authority to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) to extend the postpartum coverage period to 12-months, incorporate a new qualifying provider type under LIP, and to remove obsolete language.

The proposed amendment seeks to:

- Extend the postpartum coverage period from 60-days to 12-months,
- Authorize non-profit licensed behavioral health providers who participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers eligible to receive LIP funding; and
- Remove the requirement for the State to submit a continuance letter to CMS to continue the operation of the waiver of retroactive eligibility and the essential provider contracting requirement.

A full description of the proposed amendment request is located on the Agency for Health Care Administrations (Agency's) website at the following link: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The Agency will conduct a 30-day public notice and comment period prior to the submission of the amendment request to the Centers for Medicare and Medicaid Services. The 30-day public notice and public comment period will be held from July 26, 2021 through August 24, 2021. The Agency has scheduled a public meeting to solicit meaningful input on the proposed waiver amendment from the public. The meeting will be held:

- Webinar: August 9, 2021, 11:00 a.m. – 12:00 p.m. To participate, register via the following link: https://attendee.gotowebinar.com/register/4649340309447809547

If you have any questions about this amendment or would like to hold a call, please contact me by August 24, 2021 via email at Karen.Williams@ahca.myflorida.com.

Sincerely,

Karen Williams

GOVERNMENT OPERATIONS CONSULTANT III

Attachment II
Florida Administrative Register Notice

Notice of Meeting/Workshop Hearing

AGENCY FOR HEALTH CARE ADMINISTRATION

Medicaid

The Agency for Health Care Administration (Agency) announces public meetings to which all persons are invited.

DATES AND TIMES: August 9, 2021, 11:00 a.m. – 12:00 p.m.

PLACES: The Agency is offering both a remote and an in-person option to attend the meeting at the Agency for Health Care Administration, 2727 Mahan Drive, Building 3, Tallahassee FL 32308.

Webinar: August 9, 2021, 11:00 a.m. – 12:00 p.m. To participate, register via the following link

GoToMeeting: https://attendee.gotowebinar.com/register/4649340309447809547

GENERAL SUBJECT MATTER TO BE CONSIDERED: The State of Florida is seeking federal authority to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) to extend the postpartum coverage period to 12-months, incorporate a new qualifying provider type under LIP, and to remove obsolete language.

SUMMARY DESCRIPTION OF AMENDMENT REQUEST: Extending the postpartum coverage period from 60-days to 12-months, authorizing non-profit licensed behavioral health providers who participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers eligible to receive LIP funding, and removing the requirement for the State to submit a continuance letter to CMS to continue the operation of the waiver of retroactive eligibility and the essential provider contracting requirement.

A full description of the amendment request and the public notice document will be published on the Agency's website at the following link:

https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

PUBLIC NOTICE AND PUBLIC COMMENT PERIOD: The Agency will conduct a 30-day public notice and comment period prior to the submission of the amendment request to the Centers for Medicare and Medicaid Services. The Agency will consider all public comments received regarding the proposed amendment request. The 30-day public notice and public comment period is from July 26, 2021 to August 24, 2021. This public notice and public comment period is being held to solicit public input from recipients, providers, all stakeholders, and interested parties on the proposed amendment request for Florida's 1115 MMA Waiver.

To submit comments by postal service or email please adhere to the following instructions. When providing comments regarding the amendment request for the 1115 MMA Waiver, please put '1115 MMA Waiver-Comprehensive Amendment Request' in the subject line.

Mail comments and suggestions to: 1115 MMA Waiver-Comprehensive Amendment Request, Agency for Health Care Administration, 2727 Mahan Drive, MS 8, Tallahassee, Florida 32308. Email your comments and suggestions to FLMedicaidWaivers@ahca.myflorida.com.

A copy of the agenda may be obtained by contacting Karen Williams by email, Karen.Williams@ahca.myflorida.com

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the agency at least seven days before the workshop/meeting by contacting: Karen Williams by email, Karen.Williams@ahca.myflorida.com. If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1(800)955-8771 (TDD) or 1(800)955-8770 (Voice).

Attachment III
Provider Alert

The Agency for Health Care Administration (Agency) is announcing the start of a 30-day public notice and comment period. The State is seeking federal authority to amend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4). In this amendment, the State is seeking federal authority to extend the postpartum coverage period to 12-months, incorporate non-profit licensed behavioral health providers who participate in the coordinated system of care in counties that have implemented indigent care programs as qualifying community behavioral health providers eligible to receive LIP funding, and to remove obsolete language.

A full description of the proposed amendment request is located on the Agency's website at the following link:
https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml

The Agency announces public meetings to which all persons are invited. During the meeting, the Agency will provide a description of the amendment and allow time for public comments. The public meeting for the MMA Waiver amendment request will take place:

Webinar

August 9, 2021 from 11:00 a.m. – 12:00 p.m.

GoToMeeting: https://attendee.gotowebinar.com/register/4649340309447809547

In-Person

August 9, 2021 from 11:00 a.m. – 12:00 p.m.

2727 Mahan Dr., Building 3, Tallahassee, FL 32308

Pursuant to the provisions of the Americans with Disabilities Act, any person requiring special accommodations to participate in this workshop/meeting is asked to advise the Agency at least seven days before the workshop/meeting by contacting Karen Williams via email at Karen.Williams@ahca.myflorida.com

If you are hearing or speech impaired, please contact the agency using the Florida Relay Service, 1 (800) 955-8771 (TTY) or 1 (800) 955-8770 (Voice).

In addition to providing comment at the aforementioned public meetings, comments can be submitted via mail or email per the instructions below. The Agency will conduct the 30-day public notice and comment period from July 26, 2021 to August 24, 2021, prior to the submission of the amendment request to Centers for Medicare and Medicaid Services (CMS). The public notice and public comment period is being held to solicit public input from recipients, providers, and all stakeholders and interested parties. The Agency will consider all public comments received during the public notice and comment period regarding the proposed MMA Waiver amendment request.

Comments will be accepted from July 26, 2021 to August 24, 2021.

Mail comments and suggestions to:

1115 MMA Waiver - Comprehensive Amendment Request
Agency for Health Care Administration
2727 Mahan Drive, MS #20
Tallahassee, Florida 32308

E-mail comments and suggestions to: FLMedicaidWaivers@ahca.myflorida.com with "1115 MMA Waiver-Comprehensive Amendment Request" referenced in the subject line.

Additional information about the SMMC program can be accessed by visiting www.ahca.myflorida.com/SMMC

The Agency for Health Care Administration is committed to better health care for all Floridians. The Agency administers Florida's Medicaid program, licenses and regulates more than 45,000 health care facilities and 37 health maintenance organizations, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube (/AHCAFlorida).

HISTORICAL TREND CALCULATIONS

Expenditures and member months updated through DY14.

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED: DY11 MEG1 amount in the process of being corrected by CMS regional.

	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20
TOTAL EXPENDITURES*														
MEG 1 - SSI RELATED	$ 2,895,417,932	$ 3,101,151,925	$ 3,437,772,158	$ 3,616,664,546	$ 3,837,794,411	$ 4,034,795,456	$ 4,247,930,705	$ 4,362,172,474	$ 4,176,460,463	$ 4,734,844,995	$ 5,221,051,408	$ 5,713,434,661	$ 5,538,320,985	$ 6,445,731,892
ELIGIBLE MEMBER MONTHS	2,978,415	3,033,969	3,249,742	3,357,141	3,499,758	3,653,867	3,830,936	4,000,390	5,705,943	6,063,255	5,296,275	6,544,011	6,394,404	6,307,979
COST PER ELIGIBLE	$ 972.13	$ 1,022.14	$ 1,057.86	$ 1,077.30	$ 1,096.59	$ 1,104.25	$ 1,108.85	$ 1,090.44	$ 731.95	$ 780.91	$ 985.80	$ 873.08	$ 866.12	$ 1,021.84
TREND RATES									1,426,486	1,515,814	1,324,069	1,636,003	1,598,601	1,576,995
				ANNUAL CHANGE										
TOTAL EXPENDITURE		7.11%	10.85%	5.20%	6.11%	5.13%	5.28%	2.69%	-4.26%	13.37%	10.27%	9.43%	-3.06%	16.38%
ELIGIBLE MEMBER MONTHS		1.87%	7.11%	3.30%	4.25%	4.40%	4.85%	4.42%	42.63%	6.26%	-12.65%	23.56%	-2.29%	-1.35%
COST PER ELIGIBLE		5.14%	3.49%	1.84%	1.79%	0.70%	0.42%	-1.66%	-32.88%	6.69%	26.24%	-11.43%	-0.80%	17.98%
TOTAL EXPENDITURES*														
MEG 2 - CHILD & FAM	$ 2,429,520,901	$ 2,518,857,614	$ 2,854,235,134	$ 3,343,861,760	$ 3,623,958,323	$ 4,043,164,027	$ 4,383,305,204	$ 4,415,642,705	$ 6,171,352,881	$ 7,833,589,162	$ 8,265,387,192	$ 8,128,970,358	$ 8,627,058,706	$ 7,671,993,862
ELIGIBLE MEMBER MONTHS	15,162,819	14,829,991	17,094,840	20,033,842	21,686,199	22,956,197	24,348,400	24,667,309	25,650,237	29,235,412	32,573,333	28,606,210	27,676,242	27,493,518
COST PER ELIGIBLE	$ 160.23	$ 169.85	$ 166.96	$ 166.91	$ 167.11	$ 176.13	$ 180.02	$ 179.01	$ 240.60	$ 267.95	$ 253.75	$ 284.17	$ 311.71	$ 279.05
TREND RATES									6,412,559	7,308,853	8,143,333	7,151,553	6,919,061	
				ANNUAL CHANGE										
TOTAL EXPENDITURE		3.68%	13.31%	17.15%	8.38%	11.57%	8.41%	0.74%	39.76%	26.93%	5.51%	-1.65%	6.13%	-11.07%
ELIGIBLE MEMBER MONTHS		-2.20%	15.27%	17.19%	8.25%	5.86%	6.06%	1.31%	3.98%	13.98%	11.42%	-12.18%	-3.25%	-0.66%
COST PER ELIGIBLE		6.00%	-1.70%	-0.03%	0.12%	5.40%	2.21%	-0.56%	34.41%	11.37%	-5.30%	11.99%	9.69%	-10.48%

*** Total Expenditures in this historical tab for MEG1 and MEG2 include drugs rebates but they are not included in the MBES Schedule C; however starting with DY11, drugs rebates are part of MBES Schedule C. Starting with QE 3/31/2016, Presumptive Eligible population are now reported in 64.9 PE Waiver and amounts are not currently included on the MBES Schedule C. MBES is currently working on fixing this.**

	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20	
TOTAL EXPENDITURES**															
MEG 4 - MEDS AD	**$ 584,535,236**	**$ 374,769,277**	**$ 405,982,888**	**$ 536,897,998**	**$ 583,911,712**	**$ 669,068,962**	**$ 635,756,114**	**$ 650,969,064**	**$ 661,990,390**	**$ 697,436,358**	**$ 624,126,646**	**$ 651,017,016**	**$ 674,592,451**	**$ 684,579,080**	
ELIGIBLE MEMBER MONTHS	**422,862**	**291,688**	**311,248**	**370,314**	**450,710**	**506,112**	**495,533**	**490,260**	**466,103**	**475,566**	**455,387**	**572,944**	**581,563**	**588,524**	
COST PER ELIGIBLE	**$ 1,382.33**	**$ 1,284.83**	**$ 1,304.37**	**$ 1,449.85**	**$ 1,295.54**	**$ 1,321.98**	**$ 1,282.97**	**$ 1,327.80**	**$ 1,420.27**	**$ 1,466.54**	**$ 1,370.54**	**$ 1,136.27**	**$ 1,159.96**	**$ 1,163.21**	
TREND RATES															**DY1-DY10 7-YEAR AVERAGE**
				ANNUAL CHANGE											
TOTAL EXPENDITURE		**-35.89%**	**8.33%**	**32.25%**	**8.76%**	**14.58%**	**-4.98%**	**2.39%**	**1.69%**	**5.35%**	**-10.51%**	**4.31%**	**3.62%**	**1.48%**	**0.67%**
ELIGIBLE MEMBER MONTHS		**-31.02%**	**6.71%**	**18.98%**	**21.71%**	**12.29%**	**-2.09%**	**-1.06%**	**-4.93%**	**2.03%**	**-4.24%**	**25.81%**	**1.50%**	**1.20%**	**4.77%**
COST PER ELIGIBLE		**-7.05%**	**1.52%**	**11.15%**	**-10.64%**	**2.04%**	**-2.95%**	**3.49%**	**6.96%**	**3.26%**	**-6.55%**	**-17.09%**	**2.09%**	**0.28%**	**-3.91%**

	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20
TOTAL EXPENDITURES	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 1,000,000,000	$ 2,167,718,341	$ 1,000,000,000	$ 607,825,452	$ 1,508,385,773	$ 1,508,385,773	$ 1,508,385,773
LOW INCOME SUBSIDY POOL (LIP)	$ 998,806,049	$ 999,632,926	$ 877,493,058	$ 1,122,122,816	$ 997,694,341	$ 807,232,567	$ 1,019,291,544	$ 1,156,397,442	$ 2,077,139,740	$ 998,061,078	$ 605,175,841	$ 862,691,026	$ 619,443,653	$ 1,258,829,231
ELIGIBLE MEMBER MONTHS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
COST PER ELIGIBLE	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TREND RATES														
				LIP ANNUAL CHANGE										
TOTAL EXPENDITURE		0.08%	-12.22%	27.88%	-11.09%	-19.09%	26.27%	13.45%	79.62%	-51.95%	-39.36%	42.55%	-28.20%	103.22%
ELIGIBLE MEMBER MONTHS		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A
COST PER ELIGIBLE		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A

	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20
TOTAL EXPENDITURES														
COMBINED ALL MEGS ***WITHOUT***														
LOW INCOME SUBSIDY POOL	$ 5,324,938,833	$ 5,620,009,540	$ 6,292,007,292	$ 6,960,526,306	$ 7,461,752,734	$ 8,077,959,483	$ 8,631,235,909	$ 8,777,815,179	$ 10,347,813,344	$ 12,568,434,157	$ 13,486,438,600	$ 13,842,405,019	$ 14,165,379,691	$ 14,117,725,754
ELIGIBLE MEMBER MONTHS	18,141,234	17,863,960	20,344,582	23,390,983	25,185,957	26,610,064	28,179,336	28,667,699	31,356,180	35,298,667	37,869,608	35,150,221	34,070,646	33,801,497
COST PER ELIGIBLE	$ 293.53	$ 314.60	$ 309.27	$ 297.57	$ 296.27	$ 303.57	$ 306.30	$ 306.19	$ 330.01	$ 356.06	$ 356.13	$ 393.81	$ 415.76	$ 417.67
TREND RATES														
				MEG1 AND MEG 2 ANNUAL CHANGE										
TOTAL EXPENDITURE		5.54%	11.96%	10.62%	7.20%	8.26%	6.85%	1.70%	17.89%	21.46%	7.30%	2.64%	2.33%	-0.34%
ELIGIBLE MEMBER MONTHS		-1.53%	13.89%	14.97%	7.67%	5.65%	5.90%	1.73%	9.38%	12.57%	7.28%	-7.18%	-3.07%	-0.79%
COST PER ELIGIBLE		7.18%	-1.69%	-3.78%	-0.44%	2.46%	0.90%	-0.03%	7.78%	7.89%	0.02%	10.58%	5.58%	0.46%

	DY1 SFY 06-07	DY2 SFY 07-08	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20	
TOTAL WOW EXPENDITURES															
MEG 1 - SSI RELATED	$ 2,825,890,368	$ 3,108,877,695	$ 3,596,391,979	$ 4,012,454,923	$ 4,517,557,622	$ 4,957,018,666	$ 5,462,301,786	$ 5,994,824,438	$ 4,488,865,358	$ 5,033,835,566	$ 4,577,358,632	$ 6,723,905,862	$ 6,832,996,170	$ 7,010,246,302	
ELIGIBLE MEMBER MONTHS	2,978,415	3,033,969	3,249,742	3,357,141	3,499,758	3,653,867	3,830,936	4,000,390	5,705,943	6,063,255	5,296,275	6,544,011	6,394,404	6,307,979	
COST PER ELIGIBLE	$ 948.79	$ 1,024.69	$ 1,106.67	$ 1,195.20	$ 1,290.82	$ 1,356.65	$ 1,425.84	$ 1,498.56	$ 786.70	$ 830.22	$ 864.26	$ 1,027.49	$ 1,068.59	$ 1,111.33	STC #963
TREND RATES															
TOTAL WOW EXPENDITURES															
MEG 2 - CHILD & FAM	$ 3,024,679,134	$ 3,194,973,261	$ 3,977,627,371	$ 5,034,304,156	$ 5,885,417,547	$ 6,560,192,417	$ 7,326,920,528	$ 7,816,330,203	$ 8,314,011,319	$ 9,911,974,084	$ 11,551,806,815	$ 7,659,884,852	$ 7,751,838,622	$ 8,054,775,968	
ELIGIBLE MEMBER MONTHS	15,162,819	14,829,991	17,094,840	20,033,842	21,686,199	22,956,197	24,348,400	24,667,309	25,650,237	29,235,412	32,573,333	28,606,210	27,676,242	27,493,518	
COST PER ELIGIBLE	$ 199.48	$ 215.44	$ 232.68	$ 251.29	$ 271.39	$ 285.77	$ 300.92	$ 316.87	$ 324.13	$ 339.04	$ 354.64	$ 267.77	$ 280.09	$ 292.97	STC #963
Total WOW	$ 5,850,569,502	$ 6,303,850,956	$ 7,574,019,350	$ 9,046,759,079	$ 10,402,975,168	$ 11,517,211,082	$ 12,789,222,314	$ 13,811,154,641	$ 12,802,876,677	$ 14,945,809,651	$ 16,129,165,447	$ 14,383,790,714	$ 14,584,834,792	$ 15,065,022,271	
Variance - BN Surplus	$ 525,630,669	$ 683,841,416	$ 1,282,012,059	$ 2,086,232,774	$ 2,941,222,434	$ 3,439,251,600	$ 4,157,986,405	$ 5,033,339,462	$ 2,455,063,333	$ 2,377,375,494	$ 2,642,726,847	$ 541,385,695	$ 419,455,101	$ 947,296,517	
Cumulative Variance	$ 525,630,669	$ 1,209,472,085	$ 2,491,484,143	$ 4,577,716,917	$ 7,518,939,351	$ 10,958,190,951	$ 15,116,177,356	$ 20,149,516,818	$ 22,604,580,151	$ 24,981,955,645	$ 27,624,682,492	$ 28,166,068,187	$ 28,585,523,288	$ 29,532,819,804	
Phase-down													66%	60%	55%
Phase down Cumulative Variance												$ 357,314,559	$ 251,673,061	$ 521,013,084	
Cumulative Variance	$ 525,630,669	$ 1,209,472,085	$ 2,491,484,143	$ 4,577,716,917	$ 7,518,939,351	$ 10,958,190,951	$ 4,157,986,405	$ 9,191,325,867	$ 11,646,389,200	$ 14,023,764,694	$ 16,666,491,541	$ 17,023,806,099	$ 17,275,479,160	$ 17,796,492,244	

Carry over of accumulated savings limited to the most recent 5 years (DY7-DY11)

* MEDS AD was subject to financial cap (see application domcument). In order to calculate WOW (row 73-76), quarterly target were used.
State and CMS mutually agreed to limit the future cumulative ceiling at DY5 target; therefore, DY5 forward annual WOW expenditures remain unchanged.

Actual MMA population + voluntary population in FFS

		DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20	TREND RATE
	TOTAL EXPENDITURES *	5,618,753,356	5,754,798,623	6,242,786,667	6,912,178,867	6,741,177,246	7,643,083,744	
MEG 1	ELIGIBLE MEMBER MONTHS *	7,989,152	8,276,244	7,501,387	8,843,281	8,920,010	8,998,931	2.41%
	COST PER ELIGIBLE	$ 703.30	$ 695.34	$ 832.22	$ 781.63	$ 755.74	$ 849.33	3.85%
	TOTAL EXPENDITURES *	7,236,283,566	8,825,262,788	9,089,771,067	9,267,776,480	9,713,775,566	8,698,151,501	
MEG 2	ELIGIBLE MEMBER MONTHS *	28,689,625	31,807,333	35,175,356	31,345,181	30,585,823	30,483,830	1.22%
	COST PER ELIGIBLE	$ 252.23	$ 277.46	$ 258.41	$ 295.67	$ 317.59	$ 285.34	2.50%
	TOTAL EXPENDITURES *	761,871,703	798,883,692	733,999,486	757,299,477	783,703,154	814,530,901	
MEG 4	ELIGIBLE MEMBER MONTHS *	568,501	577,116	556,379	668,991	680,232	688,159	0.00%
	COST PER ELIGIBLE	$ 1,340.14	$ 1,384.27	$ 1,319.24	$ 1,132.00	$ 1,152.11	$ 1,183.64	2.74%

MMA voluntary population in FFS

		DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20	
	TOTAL EXPENDITURES *	$ 3,146,350,357	$ 2,945,530,066	$ 3,221,107,997	$ 3,300,737,989	$ 1,442,292,893	$ 1,019,953,628	$ 1,021,735,259	$ 1,198,744,206	$ 1,202,856,261	$ 1,197,351,852	
MEG 1	ELIGIBLE MEMBER MONTHS *	5,236,555	4,754,654	5,302,891	5,305,893	2,283,209	2,212,989	2,205,112	2,299,270	2,525,606	2,690,952	
	COST PER ELIGIBLE	$ 600.84	$ 619.50	$ 607.42	$ 622.09	$ 631.70	$ 460.89	$ 463.35	$ 521.36	$ 476.26	$ 444.95	
	TOTAL EXPENDITURES *	2,890,302,363	$ 2,955,651,564	$ 3,137,503,598	$ 3,425,003,006	$ 1,064,930,685	$ 991,673,626	$ 824,383,875	$ 1,138,806,122	$ 1,086,716,860	$ 1,026,157,639	
MEG 2	ELIGIBLE MEMBER MONTHS *	11,980,985	12,515,883	12,815,851	13,365,317	3,039,388	2,571,921	2,602,023	2,738,971	2,909,581	2,990,312	
	COST PER ELIGIBLE	$ 241.24	$ 236.15	$ 244.81	$ 256.26	$ 350.38	$ 385.58	$ 316.82	$ 415.78	$ 373.50	$ 343.16	
	TOTAL EXPENDITURES *	384,534,858	399,928,934	379,521,086	408,376,758	99,881,313	101,447,334	109,872,840	106,282,461	109,110,703	129,951,821	
MEG 4	ELIGIBLE MEMBER MONTHS *	275,937	293,588	279,346	289,913	102,398	101,550	100,992	96,047	98,669	99,635	MEDS AD
	COST PER ELIGIBLE	$ 1,393.56	$ 1,362.21	$ 1,358.61	$ 1,408.62	$ 975.42	$ 998.99	$ 1,087.94	$ 1,106.57	$ 1,105.83	$ 1,304.28	

** LTC costs have been excluded.

MEG 1	TOTAL EXPENDITURES	$ 94,641,230	$ 94,030,508	$ 101,783,548	$ 124,993,671	$ 101,055,412	$ 115,619,946	$ 125,714,661	$ 142,577,330	$ 165,928,675	$ 130,393,688	
MEG 1	MEMBER MONTHS	12,373	13,204	15,217	18,219	19,921	22,279	23,033	26,109	28,119	24,443	PPEC
	COST PER PPEC MONTH	$ 7,649	$ 7,121	$ 6,689	$ 6,861	$ 5,073	$ 5,190	$ 5,458	$ 5,461	$ 5,901	$ 5,335	

MEG 1	TOTAL EXPENDITURES	$ 26,848,491	$ 27,475,918	$ 25,464,566	$ 21,013,498	$ 21,373,855	$ 22,865,725	$ 17,891,446	$ 2,444,104	$ 2,401,023	$ 1,767,705	
MEG 1	MEMBER MONTHS	2,147	2,180	2,030	1,587	1,440	1,519	1,036	163	144	111	Nursing Home children
	COST PER NH Children MONTH	$ 12,505	$ 12,604	$ 12,544	$ 13,241	$ 14,843	$ 15,053	$ 17,270	$ 14,995	$ 16,674	$ 15,925	

*Total Expenditures and Eligible Member Months updated.

MMA AMENDMENT WITHOUT WAIVER (WOW) PROJECTION

Updated column C to read MMA trend rate which is adding Historical and voluntary population in Fee-For-Service

ELIGIBILITY GROUP	MMA TREND RATE	MONTHS OF AGING	DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL WOW
MEG 1 - SSI RELATED													
Eligible Member Months	2.41%	12	9,215,805.24	9,437,906	9,665,359.68	9,898,294.85	10,136,843.76	10,381,141.69	10,631,327.20	10,887,542.19	11,149,931.96	11,418,645.32	102,822,798
Total Cost Per Eligible President's Trend *		12	830.13										
Total Expenditure			$ 7,650,325,163										
Inpatient/Outpatient Rate	19.6%												
Self-Funded Rate	21.2%												
Total Expenditure Self-Funded Adjustment			$ 7,650,325,163										
MEG 2 - CHILD & FAMILY													
Eligible Member Months	1.22%	24	31,232,173	31,613,205.17	31,998,886.27	32,389,272.69	32,784,421.81	33,184,391.76	33,589,241.34	33,999,030.08	34,413,818.25	34,833,666.83	330,038,107
Total Cost Per Eligible President's Trend *		24	$ 273.85										
Total Expenditure			$ 8,552,861,930										
Inpatient/Outpatient Rate	57.3%												
Self-Funded Rate	21.2%												
Total Expenditure Self-Funded Adjustment			$ 8,552,861,930										
MEG 4 - MEDS AD													
Eligible Member Months	0.00%	0	688,159	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	6,881,590
Total Cost Per Eligible President's Trend *	2.74%	0	$ 1,183.64										
Total Expenditure			$ 814,530,901										
Inpatient/Outpatient Rate	19.6%												
Self-Funded Rate	21.2%												
Total Expenditure Self-Funded Adjustment			$ 814,530,901										
MEG 8 - BH SH Pilot													
Eligible Member Months	0.00%		50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	500,000
Total Cost Per Eligible State Historical Trend			$ 194.29										
Total Expenditure			$ 9,714,500										

Projections based on FY18/19 Rates
See Milliman tab for rates

Actual PMPM for DY13 (FY1819)	PCCM MEG 1	MEG 2
	$ 866.12	$ 311.71

Updated rebase to DY13 using cumulative Data from Schedule C: 1/2020

ELIGIBILITY GROUP			DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL WOW
MEG 1 COMBINED: SSI RELATED													
Eligible Member Months			9,215,805	9,437,906	9,665,360	9,898,295	10,136,844	10,381,142	10,631,327	10,887,542	11,149,932	11,418,645	102,822,798
PMPM Cost - President's Trend	4.00%		$ 830.13	$ 863.34	$ 897.87	$ 933.78	$ 971.13	$ 1,009.98	$ 1,050.38	$ 1,092.40	$ 1,136.10	$ 1,181.54	
Total Expenditure Self-Funded Adjustment			$ 7,650,325,163	$ 8,148,121,890	$ 8,678,236,497	$ 9,242,829,765	$ 9,844,193,076	$ 10,484,745,484	$ 11,166,933,469	$ 11,893,551,089	$ 12,667,437,697	$ 13,491,586,188	$ 103,267,960,318
MEG 2 COMBINED: CHILD & FAMILY													
Eligible Member Months			31,232,173	31,613,205	31,998,886	32,389,273	32,784,422	33,184,392	33,589,241	33,999,030	34,413,818	34,833,667	330,038,107
PMPM Cost - President's Trend	4.60%		$ 273.85	$ 286.44	$ 299.62	$ 313.40	$ 327.82	$ 342.90	$ 358.67	$ 375.17	$ 392.43	$ 410.48	
Total Expenditure Self-Funded Adjustment			$ 8,552,861,930	$ 9,055,286,489	$ 9,587,506,306	$ 10,150,798,060	$ 10,747,389,159	$ 11,378,927,935	$ 12,047,453,191	$ 12,755,416,117	$ 13,505,014,696	$ 14,298,523,562	$ 112,079,177,445
MEG 4 - MEDS AD													
Eligible Member Months			688,159	688,159	688,159	688,159	688,159	688,159	688,159	688,159	688,159	688,159	6,881,590
PMPM Cost - President's Trend	2.74%		$ 1,183.64	$ 1,216.07	$ 1,249.39	$ 1,283.62	$ 1,318.79	$ 1,354.92	$ 1,392.04	$ 1,430.18	$ 1,469.37	$ 1,509.63	
Total Expenditure Self-Funded Adjustment			$ 814,530,901	$ 836,849,515	$ 859,778,973	$ 883,334,656	$ 907,537,208	$ 932,400,392	$ 957,944,854	$ 984,191,239	$ 1,011,160,190	$ 1,038,865,471	$ 9,226,593,399
MEG 8 - BH SH Pilot													
Eligible Member Months			50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	500,000
PMPM Cost - President's Trend	0.00%		$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	
Total Expenditure Self-Funded Adjustment			$ 9,714,500	$ 9,714,500	$ 9,714,500	$ 9,714,500	$ 9,714,500	$ 9,714,500	$ 9,714,500	$ 9,714,500	$ 9,714,500	$ 9,714,500	$ 97,145,000

* PMPM is adjusted to account for the Self-Funded reduction for DY12-19

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

Updated column C to read MMA trend rate which is adding Historical and voluntary population in Fee-For-Service

	ELIGIBILITY GROUP	DEMO TREND RATE	MONTHS OF AGING	DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL WW
Trend Rate DY09-DY12 with 36 months of aging	**MEG 1: SSI RELATED**													
	Eligible Member Months	2.41%	12	9,215,805.24	9,437,906	9,665,360	9,898,295	10,136,844	10,381,142	10,631,327	10,887,542	11,149,932	11,418,645	102,822,798
	PMPM Cost *	3.85%	12	$ 805.93	$ 836.95	$ 869.18	$ 902.64	$ 937.39	$ 973.48	$ 1,010.96	$ 1,049.88	$ 1,090.30	$ 1,132.28	
	Total Expenditure Unadjusted			$ 7,427,261,502										
	Inpatient/Outpatient Rate	40.7%												
	Self-Funded Rate	21.2%												
	Total Expenditure Self-Funded Adjustment			$ 7,427,261,502	$ 7,899,099,456	$ 8,400,912,262	$ 8,934,604,156	$ 9,502,200,349	$ 10,105,854,707	$ 10,747,857,929	$ 11,430,646,235	$ 12,156,810,615	$ 12,929,106,656	$ 99,534,353,866
Trend Rate DY09-DY12 with 36 months of aging	**MEG 2: CHILD & FAMILY**													
	Eligible Member Months	1.22%	12	30,855,732.73	31,232,172.67	31,613,205.17	31,998,886.27	32,389,272.69	32,784,421.81	33,184,391.76	33,589,241.34	33,999,030.08	34,413,818.25	326,060,173
	PMPM Cost *	2.50%	12	$ 272.88	$ 279.70	$ 286.69	$ 293.86	$ 301.20	$ 308.74	$ 316.45	$ 324.36	$ 332.47	$ 340.79	
	Total Expenditure Unadjusted			$ 8,419,814,698										
	Inpatient/Outpatient Rate	31.6%												
	Self-Funded Rate	21.2%												
	Total Expenditure Self-Funded Adjustment			$ 8,419,814,698	$ 8,735,599,848	$ 9,063,228,521	$ 9,403,144,906	$ 9,755,809,856	$ 10,121,701,505	$ 10,501,315,919	$ 10,895,167,773	$ 11,303,791,040	$ 11,727,739,723	$ 99,927,313,790
Hypothetical Trend Rate DY09-DY12 with 36 months of aging	**MEG 4: MEDS AD**													
	Eligible Member Months	0.00%	12	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	688,159.00	6,881,590
	PMPM Cost *	2.74%	12	$ 1,111.14	$ 1,141.59	$ 1,172.87	$ 1,205.00	$ 1,238.02	$ 1,271.94	$ 1,306.79	$ 1,342.60	$ 1,379.39	$ 1,417.18	
	Total Expenditure Unadjusted			$ 764,642,365										
	Inpatient/Outpatient Rate	40.7%												
	Self-Funded Rate	21.2%												
	Total Expenditure Self-Funded Adjustment			$ 764,642,365	$ 785,593,566	$ 807,118,829	$ 829,233,885	$ 851,954,894	$ 875,298,458	$ 899,281,635	$ 923,921,952	$ 949,237,414	$ 975,246,519	$ 8,661,529,517
Hypothetical	**MEG 8 - BH SH Pilot**													
	Eligible Member Months	0.00%	-	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	500,000
	PMPM Cost *			$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	$ 194.29	
	Total Expenditure Unadjusted													

	ELIGIBILITY GROUP			DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL WW
	MEG 1 COMBINED: SSI RELATED													
	Eligible Member Months			9,215,805	9,437,906	9,665,360	9,898,295	10,136,844	10,381,142	10,631,327	10,887,542	11,149,932	11,418,645	102,822,798
	PMPM Cost *			$ 805.93	$ 836.95	$ 869.18	$ 902.64	$ 937.39	$ 973.48	$ 1,010.96	$ 1,049.88	$ 1,090.30	$ 1,132.28	
	Total Expenditure Self-Funded Adjustment			$ 7,427,261,502	$ 7,899,099,456	$ 8,400,912,262	$ 8,934,604,156	$ 9,502,200,349	$ 10,105,854,707	$ 10,747,857,929	$ 11,430,646,235	$ 12,156,810,615	$ 12,929,106,656	$ 99,534,353,866
	MEG 2 COMBINED: CHILD & FAMILY													
	Eligible Member Months			30,855,733	31,232,173	31,613,205	31,998,886	32,389,273	32,784,422	33,184,392	33,589,241	33,999,030	34,413,818	326,060,173
	PMPM Cost *			$ 272.88	$ 279.70	$ 286.69	$ 293.86	$ 301.20	$ 308.74	$ 316.45	$ 324.36	$ 332.47	$ 340.79	
	Total Expenditure Self-Funded Adjustment			$ 8,419,814,698	$ 8,735,599,848	$ 9,063,228,521	$ 9,403,144,906	$ 9,755,809,856	$ 10,121,701,505	$ 10,501,315,919	$ 10,895,167,773	$ 11,303,791,040	$ 11,727,739,723	$ 99,927,313,790
	MEG 4 : MEDS AD													

Budget Neutrality Summary

WOW Original & MMA Populations Combined			REBASING					REBASING			
	DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL
MEG 1	$ 7,650,325,163	$ 8,148,121,890	$ 8,678,236,497	$ 9,242,829,765	$ 9,844,193,076	$ 10,484,745,484	$ 11,166,933,469	$ 11,893,551,089	$ 12,667,437,697	$ 13,491,586,188	$ 103,267,960,318
MEG 2	$ 8,552,861,930	$ 9,055,286,489	$ 9,587,506,306	$ 10,150,798,060	$ 10,747,389,159	$ 11,378,927,935	$ 12,047,453,191	$ 12,755,416,117	$ 13,505,014,696	$ 14,298,523,562	$ 112,079,177,445
TOTAL	**$ 16,203,187,093**	**$ 17,203,408,379**	**$ 18,265,742,803**	**$ 19,393,627,825**	**$ 20,591,582,235**	**$ 21,863,673,419**	**$ 23,214,386,661**	**$ 24,648,967,206**	**$ 26,172,452,393**	**$ 27,790,109,750**	**$ 215,347,137,763**

WW Original & MMA Populations Combined											
	DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL
MEG 1	$ 7,427,261,502	$ 7,899,099,456	$ 8,400,912,262	$ 8,934,604,156	$ 9,502,200,349	$ 10,105,854,707	$ 10,747,857,929	$ 11,430,646,235	$ 12,156,810,615	$ 12,929,106,656	$ 99,534,353,866
MEG 2	$ 8,419,814,698	$ 8,735,599,848	$ 9,063,228,521	$ 9,403,144,906	$ 9,755,809,856	$ 10,121,701,505	$ 10,501,315,919	$ 10,895,167,773	$ 11,303,791,040	$ 11,727,739,723	$ 99,927,313,790
TOTAL	**$ 15,847,076,200**	**$ 16,634,699,305**	**$ 17,464,140,782**	**$ 18,337,749,062**	**$ 19,258,010,204**	**$ 20,227,556,211**	**$ 21,249,173,848**	**$ 22,325,814,008**	**$ 23,460,601,655**	**$ 24,656,846,379**	**$ 199,461,667,656**

VARIANCE	**$ 356,110,893**	**$ 568,709,074**	**$ 801,602,020**	**$ 1,055,878,763**	**$ 1,333,572,031**	**$ 1,636,117,207**	**$ 1,965,212,812**	**$ 2,323,153,197**	**$ 2,711,850,738**	**$ 3,133,263,371**	**$ 15,885,470,108**
CNOM HEALTHY START	$ 45,610,432	$ 63,020,962	$ 74,074,045	$ 87,065,699	$ 102,335,926	$ 120,284,358	$ 141,380,719	$ 166,177,115	$ 195,322,488	$ 229,579,591	$ 1,224,851,335
CNOM PACC	$ 369,554	$ 369,554	$ 377,352	$ 385,314	$ 393,444	$ 401,746	$ 410,223	$ 418,878	$ 427,717	$ 436,741	$ 3,990,523
CNOM HIV/AIDS	$ 41,615,240	$ 13,375,607	$ 18,633,558	$ 25,958,410	$ 36,162,661	$ 50,378,203	$ 70,181,874	$ 97,770,369	$ 136,203,901	$ 189,745,654	$ 680,025,475
NET OVERSPEND FROM HYPOS	$0	$0	$0	$0	$0	$942,114,892	$967,659,354	$993,905,739	$1,020,874,690	$1,048,579,971	$4,973,134,646
VARIANCE LESS CNOM COSTS:	**$ 268,515,668**	**$ 491,942,951**	**$ 708,517,065**	**$ 942,469,340**	**$ 1,194,680,000**	**$ 522,938,009**	**$ 785,580,643**	**$ 1,064,881,096**	**$ 1,359,021,943**	**$ 1,664,921,413**	**$9,003,468,128**

Cumulative Variance from Most Recent 5 Years (DY7-DY11) plus phase down for DY12, DY14	$ 17,796,492,244
Total Cumulative Variance	$ 26,799,960,372

LOW INCOME POOL (LIP)											
	DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL
Total Expenditures	$ 1,508,385,773	$ 1,508,385,773									$ 3,016,771,546
CMS REVISIONS: PHASE DOWN & CARRYOVER*											
MEG 1	$ (223,063,661)	$ (249,022,433.30)	$ (277,324,235.24)	$ (308,225,608.83)	$ (341,992,727.81)	$ (378,890,777.20)	$ (419,075,540.49)	$ (462,904,853.62)	$ (510,627,081.96)	$ (562,479,532.46)	$ (3,733,606,452)
MEG 2	$ (133,047,232)	$ (319,686,641)	$ (524,277,785)	$ (747,653,154)	$ (991,579,303)	$ (1,257,226,430)	$ (1,546,137,272)	$ (1,860,248,344)	$ (2,201,223,656)	$ (2,570,783,839)	$ (12,151,863,656)
REVISED VARIANCE LESS CNOM	$ (87,595,225)	$ (76,766,124)	$ (93,084,955)	$ (113,409,423)	$ (138,892,031)	$ (1,113,179,199)	$ (1,179,632,170)	$ (1,258,272,101)	$ (1,352,828,795)	$ (1,468,341,958)	$ (6,882,001,980)
CUMULATIVE VARIANCE				$ 942,469,340							
REVISED CUMULATIVE VARIANCE	**$ 17,708,897,019**	**$ 17,632,130,895**	**$ 17,539,045,940**	**$ 829,059,917**	**$ 690,167,886**	**$ (423,011,313)**	**$ (1,602,643,483)**	**$ (2,860,915,584)**	**$ (1,352,828,795)**	**$ (2,821,170,752)**	

* Phase-down of managed care savings beginning in DY13 (SFY18-19) as statewide managed care was implemented in 2014 and CMS policy is to begin rebasing after 5 years; see 'CMS Phase Down' tab for calculations

SUPPLEMENTAL HYPOTHETICAL TEST - BH SH PILOT AND MEDS AD											
Without-Waiver Total Expenditures	DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL
MEG 4 - MEDS AD	$814,530,901	$836,849,515	$859,778,973	$883,334,656	$907,537,208	$932,400,392	$957,944,854	$984,191,239	$1,011,160,190	$1,038,865,471	$9,226,593,399
MEG 8 BH SH Pilot	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$97,145,000
With-Waiver Total Expenditures											
MEG 4 - MEDS AD	$814,530,901	$836,849,515	$859,778,973	$883,334,656	$907,537,208						$4,302,031,253
MEG 8 BH SH Pilot	$9,714,500	$9,714,500	$9,714,500	$9,714,500	$9,714,500						$48,572,500
Net Overspend	**$0**	**$0**	**$0**	**$0**	**$0**	**$942,114,892**	**$967,659,354**	**$993,905,739**	**$1,020,874,690**	**$1,048,579,971**	**$0**

COSTS NOT OTHERWISE MATCHABLE (CNOM) HISTORICAL TREND

MEG 5: HIV/AIDS CNOM	DY3 SFY 08-09 **	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20	
TOTAL EXPENDITURES			$ 2,717,161	$ 3,611,956	$ 4,392,816	$ 9,042,547	$ 97,224,317	$ 105,704,316	$ 125,397,165	$ 21,443,112	$ 32,288,855	$ 13,375,607	**$ 415,197,852**
PARTICIPANT MEMBER MONTHS			915	1,242	1,570	5,008	66,949	70,569	72,026	23,522	36,724	45,650	
COST PER ELIGIBLE			$ 2,969.57	$ 2,908.18	$ 2,797.97	$ 1,805.62	$ 1,452.21	$ 1,497.89	$ 1,741.00	$ 911.62	$ 879.23	$ 293.00	
TREND RATES	ANNUAL CHANGE												2-YEAR PMPM AVERAGE
TOTAL EXPENDITURE				32.93%	21.62%	105.85%	975.19%	8.72%	18.63%	-82.90%	50.58%	-58.58%	-21.02%
ELIGIBLE MEMBER MONTHS				35.74%	26.41%	218.98%	1236.84%	5.41%	2.06%	-67.34%	56.13%	24.31%	39.31%
COST PER ELIGIBLE				-2.07%	-3.79%	-35.47%	-19.57%	3.14%	16.23%	-47.64%	-3.55%	-66.68%	-43.31%

**** Trend rate excludes DY3-DY8 for HIV/AIDS. Those years do not reflect the program's current level of operation.**

MEG 6: HEALTHY START CNOM	DY3 SFY 08-09	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20	
TOTAL EXPENDITURES	$ 15,186,146	$ 17,388,807	$ 16,465,948	$ 14,859,531	$ 15,802,519	$ 16,262,648	$ 37,077,185	$ 38,839,971	$ 43,862,782	$ 33,014,302	$ 22,618,904	$ 45,616,606	**$ 316,995,349**
PARTICIPANT MEMBER MONTHS	57,831	60,858	63,951	62,683	64,093	66,819	122,428	130,901	141,924	162,616	210,963	173,333	
COST PER MEMBER	$ 262.60	$ 285.73	$ 257.48	$ 237.06	$ 246.56	$ 243.38	$ 302.85	$ 296.71	$ 309.06	$ 203.02	$ 107.22	$ 263.17	
TREND RATES	ANNUAL CHANGE												2-YEAR PMPM AVERAGE
TOTAL EXPENDITURE		14.50%	-5.31%	-9.76%	6.35%	2.91%	127.99%	4.75%	12.93%	-24.73%	-31.49%	101.67%	17.55%
PARTICIPANT MEMBER MONTHS		5.23%	5.08%	-1.98%	2.25%	4.25%	83.22%	6.92%	8.42%	14.58%	29.73%	-17.84%	3.24%
COST PER MEMBER		8.81%	-9.89%	-7.93%	4.01%	-1.29%	24.43%	-2.03%	4.16%	-34.31%	-47.19%	145.46%	13.85%

MEG 7: PACC CNOM	DY3 SFY 08-09 **	DY4 SFY 09-10	DY5 SFY 10-11	DY6 SFY 11-12	DY7 SFY 12-13	DY8 SFY 13-14	DY9 SFY 14-15	DY10 SFY 15-16	DY11 SFY 16-17	DY12 SFY 17-18	DY13 SFY 18-19	DY14 SFY 19-20	
TOTAL EXPENDITURES	$ 269,940	$ 502,418	$ 737,812	$ 778,210	$ 690,014	$ 795,091	$ 711,095	$ 639,573	$ 469,342	$ 214,587	$ 347,115	$ 136,216	**$ 6,291,414**
PARTICIPANT MEMBER MONTHS	1,902	2,999	3,917	4,193	4,416	4,982	4,578	4,390	3,402	2,712	2,413	2,424	
COST PER ELIGIBLE	$ 141.92	$ 167.53	$ 188.36	$ 185.60	$ 156.25	$ 159.59	$ 155.33	$ 145.69	$ 137.96	$ 79.13	$ 143.85	$ 56.19	
TREND RATES	ANNUAL CHANGE												2-YEAR PMPM AVERAGE
TOTAL EXPENDITURE		86.12%	46.85%	5.48%	-11.33%	15.23%	-10.56%	-10.06%	-26.62%	-54.28%	61.76%	-60.76%	-14.00%
ELIGIBLE MEMBER MONTHS		57.68%	30.61%	7.05%	5.32%	12.82%	-8.11%	-4.11%	-22.51%	-20.28%	-11.03%	0.46%	-15.78%
COST PER ELIGIBLE		18.04%	12.44%	-1.47%	-15.81%	2.14%	-2.67%	-6.21%	-5.30%	-42.65%	81.80%	-60.94%	2.11%

**** Trend rate excludes DY3 for PACC. That year does not reflect the program's current level of operation.**

MMA AMENDMENT CNOM PROJECTION

	HISTORIC TREND RATE	MONTHS OF AGING	RENEWAL DEMONSTRATION YEARS (DY) DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL CNOM
MEG 5: HIV/AIDS CNOM													
Participant Member Months	39.31%	24	45,650	45,650	63,595	88,594	123,421	171,937	239,526	333,683	464,854	647,588	
Total Cost Per Eligible	0.00%	24	$ 911.62	$ 293.00	$ 293.00	$ 293.00	$ 293.00	$ 293.00	$ 293.00	$ 293.00	$ 293.00	$ 293.00	
Total Expenditure			$ 41,615,240	$ 13,375,607	$ 18,633,558	$ 25,958,410	$ 36,162,661	$ 50,378,203	$ 70,181,874	$ 97,770,369	$ 136,203,901	$ 189,745,654	$ 680,025,475

	HISTORIC TREND RATE	MONTHS OF AGING	DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL CNOM
MEG 6: HEALTHY START CNOM													
Participant Member Months	3.24%	24	173,324	184,747	190,733	196,912	203,292	209,879	216,679	223,700	230,947	238,430	
Total Cost Per Eligible	13.85%	24	$ 263.15	$ 341.12	$ 388.37	$ 442.15	$ 503.39	$ 573.11	$ 652.49	$ 742.86	$ 845.74	$ 962.88	
Total Expenditure			$ 45,610,432	$ 63,020,962	$ 74,074,045	$ 87,065,699	$ 102,335,926	$ 120,284,358	$ 141,380,719	$ 166,177,115	$ 195,322,488	$ 229,579,591	$ 1,224,851,335

	HISTORIC TREND RATE	MONTHS OF AGING	RENEWAL DEMONSTRATION YEARS (DY) DY15 (SFY 20-21)	DY16 (SFY 21-22)	DY17 (SFY 22-23)	DY18 (SFY 23-24)	DY19 (SFY 24-25)	DY20 (SFY 25-26)	DY21 (SFY 26-27)	DY22 (SFY 27-28)	DY23 (SFY 28-29)	DY24 (SFY 29-30)	TOTAL CNOM
MEG 7: PACC CNOM													
Participant Member Months	0.00%	36	2,413	2,413	2,413	2,413	2,413	2,413	2,413	2,413	2,413	2,413	
Total Cost Per Eligible	2.11%	36	$ 153.15	$ 153.15	$ 156.38	$ 159.68	$ 163.05	$ 166.49	$ 170.01	$ 173.59	$ 177.26	$ 181.00	
Total Expenditure			$ 369,554	$ 369,554	$ 377,352	$ 385,314	$ 393,444	$ 401,746	$ 410,223	$ 418,878	$ 427,717	$ 436,741	$ 3,990,523

	SFY 1991	SFY 1992	SFY 1993	SFY 1994	SFY 1995	SFY 1996	SFY 1997	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	Weights	Notes
1915(b)	100%	100%	100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	36%	Percentage of FL Medicaid recipients in MCOs January 2005
1115 Broward & Duval																	100%	100%	100%	100%	100%	90%	80%	70%	60%	50%	40%	30%	25%	25%	25%	25%	10%	Percentage of FL Medicaid recipients not in MCOs times percentage in Broward and Duval January 2005
1115 MMA																								100%	100%	100%	100%	100%	90%	80%	70%	60%	54%	100 percent minus above percentages
WEIGHTED AVERAGE																												66%	60%	55%	49%	44%		
																								1	2	3	4	5%						
																												66.00%	60.10%	54.70%	49.30%	43.90%		