

Florida Medicaid Section 1915(b) Managed Care Waiver

Long Term Care Managed Care Program

Proposal

Effective Dates: 7/01/13 – 6/30/16

Submitted August 1, 2011



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

Table of Contents

Acronyms/Abbreviations used in the 1915(b) Waiver Proposal	3
Facesheet	4
Section A: Program Description	6
Part 1: Program Overview	6
Part 2: Access	29
Part 3: Quality	38
Part 4: Program Operations	42
Section B: Monitoring Plan	57
Part 1: Summary Chart	59
Part 2: Monitoring Strategies	61
Section C: Monitoring Results*	71
*Not applicable to Initial Waiver Proposal	
Section D: Cost Effectiveness	73
Part 1: State Completion Section	73
Part 2: Appendices D1-7	103

Acronyms/Abbreviations used in the 1915(b) Waiver Proposal

AAHC	American Accreditation Healthcare Commission
AHCA	Agency for Health Care Administration
CAHPS	Consumer Assessment of Health Plan Survey
CMS	Centers for Medicare & Medicaid Services
DOI	Department of Insurance
EQRO	External Quality Review Organization
FFS	Fee-for-Service
HCB	Home and Community-Based
HCBS	Home and Community-Based Services
ICF/DD	Intermediate Care Facilities/Developmentally Disabled
LTC	Long Term Care
MCO	Managed Care Organization
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
SPA	State Plan Amendment
MCO	Managed Care Organization
PACE	Program of All-Inclusive Care for the Elderly
PIHP	Prepaid Inpatient Health Plan
PSN	Provider Service Network
The Act	Social Security Act
URAC	Utilization Review Accreditation Commission

Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State of Florida** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is the “Florida Long-Term Care (LTC) Managed Care Program” (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section/Part _____
 - Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
 - Document is replaced in full, with changes highlighted
- renewal request
 - This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
 - The State has used this waiver format for its previous waiver period. Sections C and D are filled out.
 - Section A is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Program Description from the previous waiver period.
 - assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.
 - Section B is replaced in full
 - carried over from previous waiver period. The State:
 - assures there are no changes in the Monitoring Plan from the previous waiver period.
 - assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This initial waiver is requested for a period of 3 years; effective July 1, 2013 and ending June 30, 2016. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

This section 1915(b) waiver will provide managed long-term care services to populations that include dual eligibles and will operate concurrently with a new section 1915(c) waiver also being submitted to CMS for approval.

State Contact: The State contact person for this waiver is **Darcy Abbott**

Darcy Abbott, LCSW
AHC Administrator
Bureau of Medicaid Services
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #20
Tallahassee, FL 32308
(850) 412-4247
Fax: (850) 414-1721
Darcy Abbott@AHCA.myflorida.com

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

All Federally recognized tribes in the State of Florida (Seminole and Miccosukee Tribes) were notified of the development of the waiver application in writing and asked to submit comments or questions directly to the Florida Medicaid program, consistent with the State of Florida's approved tribal consultation SPA #2010-011. These letters, dated June 1, 2011, are included below. Tribes were also invited to attend the public meetings held across the State and provide public input.

The state has not received any comments from any of the tribes notified of the development of the waiver application or the public meetings.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 1, 2011

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

Dear Ms. Osceola:

The State of Florida, Agency for Health Care Administration (Agency), anticipates submitting to the Centers for Medicare and Medicaid Services by August 1, 2011, an initial waiver request(s), waiver amendment(s) and/or state plan amendment(s) to implement the Statewide Medicaid Managed Care Program specified in House Bills 7107 and 7109. This letter is being sent to solicit comments from the Miccosukee Tribe of Florida on the Statewide Medicaid Managed Care Program. In addition, the tribe may want to attend one of the public meetings the Agency is holding across the state (see Attachment I) to obtain public input on the Statewide Medicaid Managed Care Program.

If you would like additional information or have any questions about the Statewide Medicaid Managed Care Program, please contact Linda Macdonald at (850) 412-4031.

Sincerely,

Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam
Enclosure

2727 Mahan Drive, MS #8
Tallahassee, Florida 32308



Visit AHCA online at
AHCA.MyFlorida.com

Attachment I Notice of Public Meetings

The notice of public meeting/workshop/hearing was submitted to the Florida Administrative Weekly (FAW) and will be published in the FAW's June 3rd publication related to the public meetings to be held on the Statewide Medicaid Managed Care Program. This information will also be posted on the Agency for Health Care Administration (Agency) website www.ahca.myflorida.com.

The format and content of the Agency's presentation will be the same at each of the meetings and the meetings will include an opportunity for public comment.

Notice of Meeting/Workshop/Hearing

The Agency announces a series of public meetings to which all persons are invited.

DATE AND TIME: June 10, 2011 from 1:00pm - 4:00pm

PLACE: Agency for Health Care Administration, Building 3, Conference Room A, 2727 Mahan Drive, Tallahassee, FL, 32308

DATE AND TIME: June 13, 2011 from 1:00pm - 4:00pmCT

PLACE: City Hall, Hagler/Mason Auditorium 2nd floor, 222 W. Main St., Pensacola, FL 32502

DATE AND TIME: June 14, 2011 from 9:00am – 12:00pm

PLACE: Department of Children and Families, 5920 Arlington Expressway, Jacksonville, FL 32211, Main Auditorium

DATE AND TIME: June 14, 2011 from 9:00am -12:00pm

PLACE: Hilton Palm Beach Airport, 150 Australian Avenue, West Palm Beach, FL 33406

DATE AND TIME: June 14, 2011 from 2:30pm – 5:30pm

PLACE: Alachua Regional Service Center, 14107 US Highway 441, Conf Rm 190-A, Alachua, FL 32615

DATE AND TIME: June 15, 2011 from 9:00am -12:00pm

PLACE: Mary Grizzle Building, Rooms 136 & 137, 11351 Ulmerton Road, Largo, FL 33778-1629

DATE AND TIME: June 16, 2011 from 9:00am – 12:00pm

PLACE: Florida Department of Transportation, Auditorium, 11201 N. McKinley Dr., Tampa, FL 33612

DATE AND TIME: June 16, 2011 from 9:00am – 12:00pm

PLACE: Marriott Fort Lauderdale North, 6650 North Andrews Avenue, Ft Lauderdale, FL 33309

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm

PLACE: El Palacio, 21485 NW – 27th Avenue, Miami Gardens, FL 33056

DATE AND TIME: June 16, 2011 from 2:00pm – 5:00pm

PLACE: Medicaid Program Office, 400 West Robinson St., Hurston Building, Conference Rooms A&D – 1st Floor Orlando, FL 32801

DATE AND TIME: June 17, 2011 from 2:00pm – 5:00pm

PLACE: Joseph D'Alessandro Bldg., 2295 Victoria Avenue, Rm. 165, Fort Myers, FL 33901

**FLORIDA
MEDICAID**
A Division of the Agency for Health Care Administration
Better Health Care for all Floridians

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 1, 2011

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

Dear Ms. Whidden:

The State of Florida, Agency for Health Care Administration (Agency), anticipates submitting to the Centers for Medicare and Medicaid Services by August 1, 2011, an initial waiver request(s), waiver amendment(s) and/or state plan amendment(s) to implement the Statewide Medicaid Managed Care Program specified in House Bills 7107 and 7109. This letter is being sent to solicit comments from the Seminole Tribe of Florida on the Statewide Medicaid Managed Care Program. In addition, the tribe may want to attend one of the public meetings the Agency is holding across the state (see Attachment I) to obtain public input on the Statewide Medicaid Managed Care Program.

If you would like additional information or have any questions about the Statewide Medicaid Managed Care Program, please contact Linda Macdonald at (850) 412-4031.

Sincerely,



Roberta K. Bradford
Deputy Secretary for Medicaid

RKB/lam
Enclosure

2727 Mahan Drive, MS #8
Tallahassee, Florida 32308



Visit AHCA online at
AHCA.MyFlorida.com

Attachment I Notice of Public Meetings

The notice of public meeting/workshop/hearing was submitted to the Florida Administrative Weekly (FAW) and will be published in the FAW's June 3rd publication related to the public meetings to be held on the Statewide Medicaid Managed Care Program. This information will also be posted on the Agency for Health Care Administration (Agency) website www.ahca.myflorida.com.

The format and content of the Agency's presentation will be the same at each of the meetings and the meetings will include an opportunity for public comment.

Notice of Meeting/Workshop/Hearing

The Agency announces a series of public meetings to which all persons are invited.

DATE AND TIME: June 10, 2011 from 1:00pm - 4:00pm

PLACE: Agency for Health Care Administration, Building 3, Conference Room A, 2727 Mahan Drive, Tallahassee, FL, 32308

DATE AND TIME: June 13, 2011 from 1:00pm - 4:00pmCT

PLACE: City Hall, Hagler/Mason Auditorium 2nd floor, 222 W. Main St., Pensacola, FL 32502

DATE AND TIME: June 14, 2011 from 9:00am - 12:00pm

PLACE: Department of Children and Families, 5920 Arlington Expressway, Jacksonville, FL 32211, Main Auditorium

DATE AND TIME: June 14, 2011 from 9:00am -12:00pm

PLACE: Hilton Palm Beach Airport, 150 Australian Avenue, West Palm Beach, FL 33406

DATE AND TIME: June 14, 2011 from 2:30pm - 5:30pm

PLACE: Alachua Regional Service Center, 14107 US Highway 441, Conf Rm 190-A, Alachua, FL 32615

DATE AND TIME: June 15, 2011 from 9:00am -12:00pm

PLACE: Mary Grizzle Building, Rooms 136 & 137, 11351 Ulmerton Road, Largo, FL 33778-1629

DATE AND TIME: June 16, 2011 from 9:00am - 12:00pm

PLACE: Florida Department of Transportation, Auditorium, 11201 N. McKinley Dr., Tampa, FL 33612

DATE AND TIME: June 16, 2011 from 9:00am - 12:00pm

PLACE: Marriott Fort Lauderdale North, 6650 North Andrews Avenue, Ft Lauderdale, FL 33309

DATE AND TIME: June 16, 2011 from 2:00pm - 5:00pm

PLACE: El Palacio, 21485 NW - 27th Avenue, Miami Gardens, FL 33056

DATE AND TIME: June 16, 2011 from 2:00pm - 5:00pm

PLACE: Medicaid Program Office, 400 West Robinson St., Hurston Building, Conference Rooms A&D - 1st Floor Orlando, FL 32801

DATE AND TIME: June 17, 2011 from 2:00pm - 5:00pm

PLACE: Joseph D'Alessandro Bldg., 2295 Victoria Avenue, Rm. 165, Fort Myers, FL 33901

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

The Florida Agency for Health Care Administration (AHCA) is submitting a 1915(b) and a 1915(c) waiver application to the Centers for Medicare & Medicaid Services (CMS) to implement the Florida Long-Term Care Managed Care Program mandated by the 2011 Florida Legislature. HB 7107 creates Section 409.978 of Florida Statutes to establish a statewide long-term care managed care program for Medicaid recipients who are (a) 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability; and (b) determined to require nursing facility level of care. AHCA will implement and administer the Florida Long-Term Care Managed Care Program in partnership with the Department of Elder Affairs (DOEA).

The specific authorities requested in the 1915(b) and (c) waiver applications will allow the State to require eligible Medicaid recipients to receive their nursing facility, hospice, and home and community-based services (HCBS) through long-term care (LTC) plans selected by the State through a competitive procurement process. Nursing facility level of care will continue to be determined by the existing Comprehensive Assessment and Review for Long-Term Care Services (CARES) units. No HCBS funding will be used to fund Nursing Facility Services. Medicaid recipients eligible for the Florida Long-Term Care Managed Care Program will have a choice of plans and may select any plan available to them in their region. The State has been divided into eleven regions, each of which is required to have a specified number of long-term care plans, which will be selected through a competitive procurement. With the implementation of Florida Long-Term Care Managed Care, four of Florida's current HCBS waivers will be phased-out, and eligible recipients will receive HCBS through the Florida Long-Term Care Managed Care Program.

In implementing and operating the Florida Long-Term Care Managed Care Program, AHCA will, together with DOEA, develop specifications for procurement, monitor plan performance, measure quality of service delivery, identify and remediate any issues, and facilitate working relationships between LTC plans and providers. Through these efforts, the state will provide incentives to serve recipients in the least restrictive setting and eligible recipients should receive improved access to care and quality of care.

The Florida Long-Term Care Managed Care Program will replace the Aged and Disabled Adult (A/DA), Assisted Living (AL), Nursing Home Diversion (NHD) and Channeling waivers currently operated by the State of Florida. AHCA will submit amendment requests to these waivers to close-out those waivers as the Florida Long-Term Care Managed Care program is implemented across the state. Medicaid recipients who, on the date long-term care (LTC) plans become available in their region, are enrolled in one of those waivers will be transitioned to the Florida Long-Term Care Managed Care Program.

In designing the service specifications for this 1915(c) waiver application, the State reviewed the service arrays offered under these waivers and the utilization of services to ensure that all current HCB service needs of transitioned waiver participants can continue to be met under this new 1915(c) waiver. The provision of enrollment broker services prior to the implementation start date will help ensure that current waiver services are delivered without interruption.

An independent enrollment broker will conduct the enrollment activities for transitioning individuals. These responsibilities will include (1) adhering to the State determined timeline for the transfer of enrollees to LTC plans; and (2) transferring all necessary provider enrollment files to effectively coordinate the suspension of current waiver services and the commencement of new waiver services.

To further enhance continuity of care for transitioned individuals, the State will ensure that: (1) payment to existing providers during the transition period is continued, and (2) LTC plans will provide for the use of out-of-plan services until the LTC plan has reviewed each enrollee's current plan of care and developed and implemented an appropriate written plan of care for transitioned individuals.

Florida anticipates that the contracts for the Long Term Care Managed Care Program will be finalized by June 2013. Florida will submit the managed care contracts to the Centers for Medicare and Medicaid Services for review as soon as the contracts are finalized.

Public Notice Summary for Waivers

AHCA has conducted extensive public outreach regarding the development and implementation of the Florida Long Term Care Managed Care program, including outreach sessions in each of the 11 geographic regions. Specific information on the public notices and regional meetings can be located on AHCA's website at: http://www.fdhc.state.fl.us/Medicaid/statewide_mc/index.shtml

The most frequently asked questions received by the Agency for Health Care Administration and AHCA's responses to those questions have been compiled into a frequently asked questions (FAQ) document and posted on AHCA's website. This document is updated periodically as new questions are received. The FAQ document can be located on AHCA's website at: http://ahca.myflorida.com/medicaid/statewide_mc/includes/long-term_care/docs/FAQ_LTC.pdf

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- a. **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- c. **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

- MCO
- PIHP
- PAHP
- PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
- FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

- a. **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State.

This waiver will be available statewide after a regional phase-in is completed. This waiver will be phased-in over a period estimated to begin July 1, 2013 and end by April 1, 2014. Once the program is fully implemented, it will be available on a statewide basis. This waiver will be implemented according to a Transition Plan that has been provided to CMS. The State considered the number of plans expected to result from

a competitive procurement, readiness, geographic areas and other factors in developing this Transition plan and phase-in schedule.

- b. X **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

- c. X **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

- d. **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

- e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a. **MCO**: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. **PIHP**: Prepaid Inpatient Health Plan means an entity that:
(1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

The PIHP is paid on a risk basis. (Capitated PIHPs and Fee for Service Provider Service Networks with a shared-savings arrangement)

On an annual basis, the Agency for Health Care Administration will total all paid claims for covered services provided under the contract, in addition to an administrative per member per month advance payment. This total will be compared to the total amount of what would have been paid under a capitated model. If the total Fee-For-Service PSN costs are less than what would have been paid under a capitated model, the PSN will be able to keep the savings, less the administrative allocation. If the total cost is more than what would have been paid under a capitated model, then the PSN must repay a portion of the administrative allocation in accordance with the contract.

The PIHP is paid on a non-risk basis.

c. **PAHP**: Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

The PAHP is paid on a risk basis.

The PAHP is paid on a non-risk basis.

- d. **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.
- e. **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
 the same as stipulated in the state plan
 is different than stipulated in the state plan (please describe)
- f. **Other:** (Please provide a brief narrative description of the model.)

2. **Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

- Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement
- Other** (please describe)

Qualified Medicare Advantage plans that exclusively serve dual eligibles may opt to participate as a Medicaid Long Term Managed Care plan without participating in a competitive procurement process.

The current law states: *Participation by a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan shall be pursuant to a contract with the agency and not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of recipients who are deemed dually eligible for Medicaid and Medicare services. Otherwise, Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-Sponsored Organizations, and Medicare Advantage Special Needs Plans are subject to all procurement requirements.*

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

- Two or more MCOs
- Two or more primary care providers within one PCCM system.
- A PCCM or one or more MCOs
- Two or more PIHPs.
- Two or more PAHPs.
- Other: (please describe)

In each of the 11 geographic regions of the State, enrollees will have a choice of at least two PIHPs. The State anticipates contracting with two to ten PIHPs in each region, depending on the size of the region and qualifications of the interested plans.

3. Rural Exception.

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting

- Beneficiaries will be limited to a single provider in their service area (please define service area).
- Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

Statewide -- all counties, zip codes, or regions of the State

The State of Florida will implement this 1915(b) waiver statewide after a regional phase-in of enrollment, estimated to begin July 1, 2013 and end by April 1, 2014. See the next item for a listing for counties by region

Less than Statewide

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)*
Region 1. Counties: Escambia, Santa Rosa, Walton, and Okaloosa	PIHP MCO	American Eldercare, Inc., Sunshine State Health Plan
Region 2 Counties: Holmes, Washington, Jackson, Leon, Gadsden, Liberty, Calhoun, Franklin Wakulla, Jefferson, Madison, Gulf, Bay, and Taylor	PHIP MCO	American Eldercare, Inc., Sunshine State Health Plan
Region 3 Counties: Hamilton, Suwannee, Columbia, Union, Gilchrist, Alachua, Marion, Lake, Sumter, Levy, Dixie, Lafayette, Bradford, Citrus, Hernando, and Putnam	PHIP MCO MCO	American Eldercare, Inc., Sunshine State Health Plan, United Healthcare of Florida, Inc.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)*
Region 4 Counties: Baker, Nassau, Duval, Flagler, Clay, St. Johns, and Volusia	PIHP PIHP	American Eldercare, Inc., Sunshine State Health Plan, United Healthcare of Florida, Inc.
Region 5 Counties: Pinellas and Pasco	PIHP PIHP PIHP	American Eldercare, Inc., Sunshine State Health Plan, United Healthcare of Florida, Inc.
Region 6 Counties: Hillsborough, Manatee, Polk, Hardee, and Highlands	PIHP PIHP PIHP PIHP	American Eldercare, Inc., Sunshine State Health Plan, United Healthcare of Florida, Inc., Coventry Healthcare of Florida, Inc.
Region 7 Counties: Orange, Osceola, Brevard, and Seminole	PIHP PIHP PIHP PIHP	American Eldercare, Inc., Sunshine State Health Plan, United Healthcare of Florida, Inc., Coventry Healthcare of Florida, Inc.
Region 8 Counties: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	PIHP PIHP PIHP	American Eldercare, Inc., Sunshine State Health Plan, United Healthcare of Florida, Inc.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)*
Region 9 Counties: Okeechobee, Indian River, St. Lucie, Martin and Palm Beach	PIHP PIHP PIHP PIHP	American Eldercare, Inc., Sunshine State Health Plan, United Healthcare of Florida, Inc., Coventry Healthcare of Florida, Inc.
Region 10 County: Broward	PIHP PIHP PIHP	American Eldercare, Inc., Sunshine State Health Plan, Amerigroup Florida, Inc.
Region 11 Counties: Miami-Dade and Monroe	PIHP PIHP PIHP PIHP PIHP	American Eldercare, Inc., Sunshine State Health Plan, United Healthcare of Florida, Inc., Coventry Healthcare of Florida, Inc., Amerigroup Florida, Inc.

*Procurement and contracting are not completed, these entities are subject to change .

Long Term Managed Care Program Provider Procurement Limits

Regions	Related Counties	Maximum # of PIHPs	Minimum # of PIHPs
1	Escambia, Santa Rosa, Walton, and Okaloosa	2	2
2	Holmes, Washington, Jackson, Leon, Gadsden, Liberty, Calhoun, Franklin Wakulla, Jefferson, Madison, Gulf, Bay, and Taylor	2	2
3	Hamilton, Suwannee, Columbia, Union, Gilchrist, Alachua, Marion, Lake, Sumter, Levy, Dixie, Lafayette,	5	3

	Bradford, Citrus, Hernando, and Putnam		
4	Baker, Nassau, Duval, Flagler, Clay, St. Johns, and Volusia	5	3
5	Pinellas and Pasco	4	2
6	Hillsborough, Manatee, Polk, Hardee, and Highlands	7	4
7	Orange, Osceola, Brevard, and Seminole	6	3
8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota	4	2
9	Okeechobee, Indian River, St. Lucie, Martin and Palm Beach	4	2
10	Broward	4	2
11	Miami-Dade and Monroe	10	5

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

- Mandatory enrollment
- Voluntary enrollment

Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

- Mandatory enrollment
- Voluntary enrollment

Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

Mandatory enrollment (*for individuals determined to require a Nursing Facility Level of Care*)

Voluntary enrollment

Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

Mandatory enrollment

Voluntary enrollment

Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

Mandatory enrollment (*for individuals determined to require a Nursing Facility Level of Care*)

Voluntary enrollment

Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

Mandatory enrollment

Voluntary enrollment

TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

Mandatory enrollment

Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

Medicare Dual Eligible--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

X **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

Other Insurance--Medicaid beneficiaries who have other health insurance.

X **Reside in Nursing Facility or ICF/MR**--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

This waiver population excludes Medicaid participants who reside in any Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) licensed by the State of Florida. Medicaid participants who reside in Nursing Facilities are included in the waiver population.

X **Enrolled in Another Managed Care Program**--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

This waiver excludes Medicaid participants who enroll in PACE.

X **Eligibility Less Than 3 Months**--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

X **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

This section 1915(b) waiver for the Florida LTC Managed Care Program will operate concurrently with a new section 1915(c) waiver that the State of Florida is also submitting to CMS. The new 1915(c) waiver for the Florida LTC Managed Care Program will subsume the HCBS waivers listed below and participants currently enrolled in these individual HCBS waivers will be included in this new 1915(b)/(c) concurrent Florida LTC Managed Care waiver program as enrollment into mandatory managed care is phased-in:

- (1) The Assisted Living Waiver*
- (2) The Aged and Disabled Adult Waiver*
- (3) The Channeling Services Waiver for Frail Elders*
- (4) The Nursing Home Diversion Waiver (currently under concurrent 1915(a)/1915(c) authorities)*

Participants in HCBS Waivers other than those listed above will be excluded from enrollment in this waiver unless they choose to enroll in this waiver and disenroll from their current waiver.

American Indian/Alaskan Native--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

The State of Florida assures that it will comply with the provisions of section 1932(h) of the Social Security Act that govern contracts with managed care plans and the treatment of Indians and Indian health care providers.

Special Needs Children (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.

Other (Please define):

Medicaid participants in the following programs or eligibility groups are excluded from this waiver:

- ***PACE (noted earlier under “Enrolled in Another Managed Care Program”)***
- ***Women who are eligible only for family planning services (Family planning 1115 demonstration waiver enrollees)***
- ***Women who are eligible through the breast and cervical cancer services program***
- ***Persons who are only eligible for emergency services***
- ***Refugee eligibles***
- ***Medically Needy***
- ***Individuals determined to not require a nursing facility level of care***
- ***Individuals under age 18***

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

Covered Services	
Nursing Facility Services	Intermittent and skilled nursing
Assisted Living Services	Medication administration
Hospice	Medication management
Adult Day Health Care	Nutritional assessment and risk reduction
Medical equipment and supplies, including incontinence supplies	Caregiver training
Personal Care Services	Respite care
Home accessibility adaptation	Transportation to waiver services
Behavior management	Personal emergency response system
Home-delivered meals	Companion (aka: adult companion)
Case management	Attendant care
Therapies (speech, occupational, respiratory, physical)	Homemaker
Assistive Care Services	Home health

1. Assurances.

 X The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b) *Note: Family planning services are not a covered service under this waiver.*

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will

apply, and what the State proposes as an alternative requirement, if any.
*-(See note below for limitations on requirements that may be waived).

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

_____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

X The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

X The PIHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

Emergency services are not included in this waiver program.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network

providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

- The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
 - The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
 - The State will pay for all family planning services, whether provided by network or out-of-network providers.
 - Other (please explain):
- Family planning services are not included under the waiver.

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

- The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
- The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

- The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

___ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

N/A The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards. NOTE – There is no PCCM component included under this waiver program.

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services. N/A

a. **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. PCPs (please describe):

2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Hospitals (please describe):
6. ___ Mental Health (please describe):
7. ___ Pharmacies (please describe):
8. ___ Substance Abuse Treatment Providers (please describe):
9. ___ Other providers (please describe):

b. ___ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Urgent care (please describe):
8. ___ Other providers (please describe):

c. ___ **In-Office Waiting Times:** The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):

4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program. **N/A**

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards. NOTE – There is no PCCM component included under this waiver program.

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program. N/A

- a. ___ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
- b. ___ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.
- c. ___ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.
- d. ___ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1.			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

- e. ___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.
- f. ___ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

<i>Area(City/County/Region)</i>	<i>PCCM-to-Enrollee Ratio</i>

<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

g. ___ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver. **N/A**

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

- a. X The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

Based on the eligible population and scope of services, the State has determined that all enrollees of the waiver have special health care needs and, therefore, separate identification of enrollees with special health care needs within this waiver is unnecessary.

The scope of services covered in this waiver is limited to institutional and HCB waiver services provided by Long Term Care (LTC) Managed care Plans that qualify as PIHPs. Primary, acute and behavioral health care services are "carved-out" and will become the responsibility of Medicare for Medicare individuals and the Managed Medical Assistance Program managed care plans beginning in Year 2 of this waiver. The LTC managed care plans will be required to coordinate with the Managed Medical Assistance Managed Care Plans. Individuals enrolled in the

LTC Managed Care Program will identified as individuals with special health care needs in the Managed Medical Assistance program upon expansion of that program.

Managed care plans will be required to have policies and procedures to manage this scenario. The state reviews all policies and procedures during the plan readiness review period. Satisfactory policies and procedures are a condition of approval to begin enrolling recipients. Furthermore, the state requires plans to include language in their residential provider contracts detailing the provider's responsibility to conform to the home-like environment characteristics and community inclusion goals as detailed in the waiver application. Plans are required to monitor providers for compliance prior to receiving enrollees under the waiver. The state will assess whether the chosen plans have incorporated the required provider contracts and their monitoring efforts during the plan readiness period. The state is also incorporating these requirements at the provider level. It will conduct training sessions with ALF's and ALF associations in February, and is incorporating these critical requirements into its monitoring and licensing protocols.

Are any of the LTC plans currently contracted with providers who would be providing services identified in the 1915 (b) (c) waiver?

Contract awards were announced January 15, 2013 and it is too soon for the state to attest whether or not the successful LTC plans are currently contracted with providers. Florida Statute (s. 409.982(1)(c)) requires every long term care managed care plan to offer network contracts to all nursing facilities, hospices, and to all current aging service providers in their region. This requirement will help ensure continuity of care by giving current long term care service providers the opportunity to continue serving current clients.

Managed care plans are required to continue transitioning enrollees services at the same level, and with the providers identified in the transition plan and plan of care for up to 60 days after transition, or until the plan has completed its required reassessments, developed a new person-centered care plan, and made provision for services with providers. If a plan cannot deliver the services required with providers in its network, it must continue to make provisions for services with the enrollee's out-of-network provider. In the instance an enrollee's provider leaves the plan, the enrollee may select another service provider, or may request to change managed care plans. An enrollee may change plan within 90 days of enrollment for any reason, and for cause thereafter. The state considers for cause disenrollments on a case-

by-case basis. A recipient wishing to switch plans in order to retain their historical service provider would be considered for good cause.

- b. ___ **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.
- c. ___ **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.
- d. ___ **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
 - 1. ___ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
 - 2. ___ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
 - 3. ___ In accord with any applicable State quality assurance and utilization review standards.
- e. ___ **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees. N/A

- a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
- c. ___ Each enrollee is receives **health education/promotion** information. Please explain.

- d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. ___ There is appropriate and confidential **exchange of information** among providers.
- f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. ___ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
- i. ___ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program. **N/A**

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** will be submitted to the CMS Regional Office with the managed care plans' contracts for CMS approval. **Florida anticipates that the contracts for the Long Term Care Managed Care Program will be finalized by June 2013. The state's quality strategy is found in Attachment A.**

X The State assures CMS that it will comply with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
PIHP	TBD*	TBD*	X	TBD*

*The State contracts with an independent External Quality Review Organization. This contract expires June 30,, 2013. The State will procure an EQRO vendor to begin work under a new contract beginning July 2013. The term of the new contract will be five years with the option for five one-year renewals.

2. **Assurances For PAHP program.** N/A

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program. N/A

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. ___ **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. ___ Provide education and informal mailings to beneficiaries and PCCMs;
2. ___ Initiate telephone and/or mail inquiries and follow-up;
3. ___ Request PCCM's response to identified problems;
4. ___ Refer to program staff for further investigation;
5. ___ Send warning letters to PCCMs;

6. ___ Refer to State's medical staff for investigation;
7. ___ Institute corrective action plans and follow-up;
8. ___ Change an enrollee's PCCM;
9. ___ Institute a restriction on the types of enrollees;
10. ___ Further limit the number of assignments;
11. ___ Ban new assignments;
12. ___ Transfer some or all assignments to different PCCMs;
13. ___ Suspend or terminate PCCM agreement;
14. ___ Suspend or terminate as Medicaid providers; and
15. ___ Other (explain):

- c. ___ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
 - A. ___ Initial credentialing

B. ___ Performance measures, including those obtained through the following (check all that apply):

- ___ The utilization management system.
- ___ The complaint and appeals system.
- ___ Enrollee surveys.
- ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ___ Other (please describe).

d. ___ **Other quality standards** (please describe):

4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted: **N/A**

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. **Scope of Marketing**

1. The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3. X The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

Marketing is permitted at health fairs and public events for the primary purpose of providing community outreach. All marketing activities must be approved by the State in advance of managed care plan participation and all marketing materials must be approved by the State prior to distribution.

b. **Description.** Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. X The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

Florida Statutes Section 409.9122(2)(d), provides that managed care plans are prohibited from providing inducement to Medicaid recipients to select their plans or from prejudicing Medicaid recipients against other managed care plans. The State monitors this prohibition through on-site surveys and a Consumer Complaint hotline.

2. ___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. X The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

- i. ___ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii. X The languages comprise all languages in the service area spoken by approximately 5 percent or more of the population.
- iii. ___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. **Non-English Languages**

Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as:
(check any that apply):

1. The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. The languages spoken by approximately 5 percent or more of the potential enrollee/ enrollee population.
3. Other (please explain):

Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

The State requires that each Long Term Managed Care plan provide enrollees with 24 hours/7 days a week access for questions, assistance and emergencies. Regarding translations, the State requires Long Term Managed Care plans to provide translation for all means of communications and all languages. This includes the provision of TTY/TDD services, Braille materials, and audiotapes for hearing, speech and visual impaired enrollees and potential enrollees. For oral translation services, the contractor is required to provide interpreter services in person where practical, but otherwise by telephone, for enrollees or potential enrollees whose primary language is not English.

The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

The State will contract with an independent enrollment broker to handle outreach, informing and enrollment-related activities.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

State
 contractor (please specify) An independent enrollment broker will be responsible for providing required information to potential enrollees.

There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- (i) the State
- (ii) State contractor (please specify): Automated Health Systems (AHS)
- (ii) the MCO/PIHP/PAHP/PCCM/FFS selective contracting providers.

C. Enrollment and Disenrollment

1. Assurances.

The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The State of Florida has conducted public information sessions, including outreach to tribal organizations, about this new program in each of the State's 11 geographic regions. The State will contract with an independent enrollment broker to handle outreach, informing and enrollment-related activities.

The State will develop strategies to inform potential enrollees, providers, and others of the Florida Long Term Care Managed Care Program. The outreach and education efforts will help to facilitate the transition of all affected individuals by ensuring they are informed of changes and potential impacts. The State will assess all current outreach strategies to identify additional information that will be needed to conduct effective outreach for this new program.

Outreach activities will be targeted towards providers, advocates, other agencies, current and potential Medicaid participants, and other stakeholders. To accomplish this, the State will develop strategic partnerships with community providers, including the local Aging Resource Centers and other entities, to provide increased awareness of the Florida LTC Managed Care program in each geographic region. The Medicaid Area Offices will help to coordinate local efforts. Education activities will focus on informing current and potential Medicaid enrollees of the Florida LTC Managed Care program and the benefits of coordinating institutional and HCB long-term care services under one contracted managed care organization.

b. Administration of Enrollment Process.

State staff conducts the enrollment process.

The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Automated Health Systems

Please list the functions that the contractor will perform:

choice counseling

enrollment

other (please describe):

State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. Enrollment. The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

Implementation will be phased-in over 11 geographic regions covering the State. Enrollment will be phased-in over a period, estimated to begin in July 2013 and end by April 1, 2014. The State has developed the following detailed implementation schedule:

Long-Term Care Managed Care Implementation Schedule

Regions	Recipient and Stakeholder Outreach and Education	Date Initial Medicaid Notice Letters Mailed	Enrollment Date
7	December 2012	May 20, 2013	August 1, 2013
8 and 9	January 2013	June 24, 2013	September 1, 2013
1, 2 and 10	March 2013	August 26, 2013	November 1, 2013
*11	April 2013	September 23, 2013	December 1, 2013
5 and 6	June 2013	November 25, 2013	February 1, 2014
3 and 4	July 2013	December 23, 2013	March 1, 2014

***The Region 11 implementation includes Frail Elder Option plan members served under United Health Care of Florida's Section 1915 (b) (3) program. This program operates only in Miami-Dade County.**

Please outline, in detail, a plan to describe how the state will ensure beneficiary access to care if the beneficiary does not get an enrollment card or is unaware of LTC assignment during initial implementation

The Agency, in partnership with the Department of Elder Affairs (DOEA), is working to ensure all affected recipients are appropriately notified prior to the initial implementation. In fostering this objective, the state has begun providing education and training for providers and entities that have regular contacts with the long-term care (LTC) population. Training for these entities will be delivered through face-to-face meetings, webinars and technical assistance calls. In addition, providers in the four feeder waivers are required to ensure their Medicaid recipient clients' addresses and contact information is up-to-date. Providers are required to send the updated information to the state prior to implementation, which will then be entered into the enrollment broker system. DOEA houses and monitors the database which is updated by providers on a daily basis and audited by the state on a monthly basis. The enrollment system is a redundant measure and is separate from the eligibility system. The state developed this practice to mitigate limitations of the eligibility system which is updated periodically by recipients self-reporting changes in contact information and during periodic eligibility redeterminations. This will help ensure affected beneficiaries receive all information about enrollment.

Recipients in the four feeder waivers, as a requirement of program operations, have case managers who coordinate their care and ensure services are provided in accordance with the enrollee's plan of care. During the initial implementation of the LTC managed care program, the case managers from the feeder waivers will collaborate with the LTC managed care plan responsible for coordination of care for the LTC enrollees during the transition into the LTC plan. This close coordination will ensure continuity of care and the continued provision of services, and addresses any barriers to services or access to care as a result of the enrollee not receiving an enrollment card or being unaware of their LTC plan assignment. Managed care plan case managers present Fair Hearing information during orientation to the plan, and recipients receive this information in their member handbook. In the event the managed care plan makes a potentially adverse decision, the case manager informs the recipient and the plan provides formal written notification.

In the event an enrollee is already receiving prior authorized services from any provider, the managed care plan will be responsible for the costs of continuing these services. The state requires the LTC plan to continue services unabated for up to 60 days, or until the enrollee receives a comprehensive assessment, a plan of care is developed, and services are arranged and authorized as required to address the long-term care needs of the LTC enrollee. The state requires the managed care plan to develop a person-centered plan of care within five business days of the enrollee's effective date of enrollment for enrollees in the community (including ALFs and adult family care homes) and within seven business days of the effective date of enrollment for those enrolled in a nursing facility.

Describe the transition process for those beneficiaries who will be new to managed care as well as those beneficiaries who are currently enrolled with a plan that will not continue under the new waiver.

The Agency will send affected Medicaid recipients a notice, followed by an enrollment information package, including important action dates prior to each region's transition date. Whether recipients are currently enrolled in a managed care plan or not they will be directed to review the materials and receive telephonic or face-to-face choice counseling to choose the best plan for their needs. The Agency will automatically enroll recipients into an LTC plan if they do not select a plan of their own volition based on the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipients.

Considerations include, but are not limited to, the plan's enrollment capacity; whether the plan has established provider contracts with all required providers in the region (i.e., nursing facilities, hospices, aging services providers that have recently served recipients); network adequacy standards including whether the plan, at a minimum, has two providers for each service type per county; and, for nursing facilities, assisted living facilities, and adult day health care centers, the geographical proximity of the plan's providers to the recipient.

(b) Whether the recipient is enrolled in that plan through the Nursing Home Diversion waiver.

The state is also considering whether we can make an assignment based on the recipient's key care providers being part of a plan's network. While the state can readily determine this information for transitioning recipients in fee-for-service waivers, it is exploring if, and how, it can reliably collect this information for transitioning recipients who are already in managed care.

A recipient who is automatically enrolled in a plan retains the right to change plans during open enrollment and for cause thereafter.

Once a recipient has chosen or is assigned to a managed care plan, the Agency will notify the plan of the new enrollee. Managed care plans are required to send new enrollees a welcome enrollment package by the first day of enrollment or within five calendar days following receipt of the enrollment file from Medicaid or its agent, whichever is later. Managed care plans are required to continue a new enrollee's services for up to sixty days after enrollment, or until they complete the required case management and care plan assessments. Irrespective of whether a recipient has transitioned from another plan or not, their care will continue unabated until the new managed care plan has finished its required assessments. Recipients retain their right to a Fair Hearing to challenge plan determinations and their right to continue services at their current level until the appeal is exhausted. DOEA will audit care plans that are reduced as a result of the new managed care plan's assessments.

All current Nursing Home Diversion waiver managed care plans are required to develop transition plans for their enrollees on the basis of:

- If the plan is awarded a contract under the long-term care managed care program.*
- If the plan is not awarded a contract and will continue to serve enrollees until the transition date in all regions served.*
- If the plan is not awarded a contract and will end its contract early and stop serving enrollees prior to the date of transition.*

DOEA will assess these transition plans to determine whether they meet the extensive transition plan requirements contained in its current provider contract

and to determine which of the three options above the plan intends to pursue.

All managed care plans that win contracts to provide managed long term care services under the new waiver are required to submit transition plans. The Agency will assess the transition plans during the plan readiness period after contract awards and prior to the “go live” date in the region.

The Agency and DOEA are exploring ways to aid the efficient transfer of recipient information from one plan to another to further ensure transitioning recipients’ existing plan of care and assessment information is provided to the appropriate managed care plan in a timely manner.

Describe the state’s strategy to assist beneficiaries entering the long-term managed care program with enrollment, choice counseling, and complaints. Please describe the state’s ability to provide beneficiary assistance through call centers, ADRC assistance, and the independent advocacy/Ombudsman

The Agency has worked closely with its partner agency, the Department of Elder Affairs, and other stakeholders to ensure recipients who will, or may, be affected by the transition to managed care will be supported throughout the process and post-implementation. The current recipient support framework, which includes Medicaid Area Offices, Long-Term Care Ombudsman, Aging and Disabilities Resource Centers, aging and disability advocacy groups and the state’s extensive open government and public policy development and adoption process (which affords significant citizen involvement), will continue to serve recipients after long-term care managed care is implemented. The state is focusing its initial outreach and education efforts on these stakeholder groups and on long term care providers, as the long term care recipients are likely to contact them with questions.

The Agency will support recipients through the enrollment process by providing pre-transition written information and choice counseling, and by facilitating enrollment in the selected managed care plan via its enrollment broker. The enrollment broker can be reached via toll-free call center or selection can be made through a secure web-based application. Recipients will continue to be able to contact the Agency and its partners for clarification and help with complaints or issues they may have. Recipients retain the right to petition the state, through the Department of Children and Families, for a Fair Hearing and may also engage the Agency’s Beneficiary Assistance Program (BAP) in grievances they may have with the managed care plan. The Agency will also support recipients’ choice to change managed care plans within the 90 day open enrollment period each year and for cause thereafter.

Managed care plans selected for this program are required to develop a robust enrollee information program that includes detailed information about the various important aspects of the enrollee’s care. Information is to be disseminated in writing via various forms of required communication (example: enrollee welcome package). Managed care plans are required to maintain a website from which enrollees can obtain general information without logging in, and personal information through a secure

mechanism. Additionally, plans are required to maintain a strict level of personal contact as part of their case management requirements affording recipients the opportunity to discuss questions or issues they may have with someone familiar with their needs. Lastly, plans must operate an enrollee customer service line to answer questions and resolve enrollee issues. These requirements will be monitored by the state via the document approval process, managed care plan reporting requirements and annual monitoring.

Please provide a protocol for notifying, offering choice, and transitioning beneficiaries who may reside in a non-compliant ALF or ALF under CAP when the beneficiary is enrolled into the waiver.

Managed care plans will be required to have policies and procedures to manage this scenario. The state reviews all policies and procedures during the plan readiness review period. Satisfactory policies and procedures are a condition of approval to begin enrolling recipients. Furthermore, the state requires plans to include language in their residential provider contracts detailing the provider's responsibility to conform to the home-like environment characteristics and community inclusion goals as detailed in the waiver application. Plans are required to monitor providers for compliance prior to receiving enrollees under the waiver. The state will assess whether the chosen plans have incorporated the required provider contracts and their monitoring efforts during the plan readiness period. The state is also incorporating these requirements at the provider level. It will conduct training sessions with ALF's and ALF associations in February, and is incorporating these critical requirements into its monitoring and licensing protocols.

Managed care plans are required to notify their enrollees if they reside in a non-compliant ALF or adult family care home. The plan will follow its standard notification procedure of sending written notification to the enrollee coupled with personal contact via the case manager. The case manager will meet with the resident, and others chosen by the resident, to discuss the ALFs or adult family care homes in the plan's network that are compliant. The case manager may facilitate visits to the prospective residences, if desired by the enrollee. Once the enrollee has chosen a new residence, the case manager will facilitate the move.

If a recipient chooses to remain in an ALF or adult family care home after being informed of his options he may be disenrolled from the waiver. Disenrolling a recipient as a result of their choice to remain in a facility that is non-compliant is an extreme, last resort, measure and would only be considered after the managed care plan and the state were unable to resolve the issue to the resident's satisfaction. Though a last resort, it may be necessary to disenroll a resident due to the federal requirements for claiming participation funds.

In the case of an involuntary disenrollment, the state requires managed care plans to submit the case notes, care plan, disenrollment recommendation, and other pertinent documentation to DOEA. The DOEA Clinical Quality Monitors will review the case record and make a recommendation to the Agency on whether to approve the disenrollment. An involuntary disenrollment must be approved by the Agency. In the event of an involuntary disenrollment under these circumstances, the Aging and Disability Resource Centers will work with the affected recipient to assist in finding long term care services that are not funded by Medicaid.

Are any of the LTC plans currently contracted with providers who would be providing services identified in the 1915 (b) (c) waiver?

Contract awards are not expected until January 15, 2013 and so the state cannot attest to whether the successful LTC plans are currently contracted with providers. Florida Statute (s. 409.982(1)(c)) requires every long term care managed care plan to offer network contracts to all nursing facilities, hospices, and to all current aging service providers in their region. This requirement will help ensure continuity of care by giving current long term care service providers the opportunity to continue serving current clients.

Managed care plans are required to continue transitioning enrollees services at the same level, and with the providers identified in the transition plan and plan of care for up to 60 days after transition, or until the plan has completed its required reassessments, developed a new person-centered care plan, and made provision for services with providers. If a plan cannot deliver the services required with providers in its network, it must continue to make provisions for services with the enrollee's out-of-network provider. In the instance an enrollee's provider leaves the plan, the enrollee may select another service provider, or may request to change managed care plans. An enrollee may change plan within 90 days of enrollment for any reason, and for cause thereafter. The state considers for cause disenrollments on a case-by-case basis. A recipient wishing to switch plans in order to retain their historical service provider would be considered for good cause.

Please explain in detail how the LTC plans will recruit for provider types not currently in the existing 1915(c) waivers.

Adult family care homes, health care services pools, and non-emergency transportation providers are the only provider types that are not included in the four 1915(c) feeder waivers. Managed care plans that bid on the long term care ITN had to demonstrate that they already had contracts or letters of agreement with at least two providers of each service in each county where they bid. (The exception to this is transportation, where they only had to have one provider.) Thus, they have already demonstrated that they can recruit sufficient providers to serve the population. The managed care plans

must undergo validation of their complete network by the state during the plan readiness phase.

Does the state plan to conduct recipient/ stakeholder outreach and education more than once in each region prior to implementation?

The state will pursue multiple outreach and education initiatives on a continual basis before, and during, managed care implementation. The state has provided these drafts to advocates for review and is awaiting their input. Initial correspondence is designed to inform recipients of the impending change and engage in the process. It refers them to online and personal sources for more information so they can make an informed choice, and details the steps they need to take to obtain further information and choice counseling prior to plan selection. The initial correspondence will be followed by enrollment information detailing managed care plan choices and details on how to select a plan.

The Agency and the Department of Elder Affairs will also conduct statewide education and outreach trainings session and seminars for both recipients and other stakeholders, and incorporate references to managed care into existing outreach opportunities as appropriate. Outreach materials are currently under development.

The Agency has a webpage with information about the managed care program. It also allows for people to sign up for automatic updates. The address is: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml

Provider Credentialing: What is the LTC health plans responsibility for provider credentialing?

LTC plans are responsible for credentialing and re-credentialing network providers to ensure they meet the minimum Agency Medicaid participation criteria. Plans must ensure providers:

- Meet minimum licensing standards as defined in the LTC managed care contract agreement.*
- Have not had their license revoked or suspended, and are not under a moratorium at the behest of the Agency or Department of Health.*
- Have valid Level 2 background checks for all appropriate staff.*
- Have made the appropriate ownership, management, business transaction and conviction disclosures.*
- Have disclosed their professional liability claims history.*
- Have disclosed any Medicaid or Medicare sanctions.*

- *Have demonstrated a current Medicaid ID number, Medicaid provider registration number, or submission of the Medicaid provider registration form.*

Plans are required to develop written credentialing policies and procedures designating the process for conducting and verifying provider credentialing and re-credentialing and maintain credentialing files.

The state reviewed basic licensing information for the provider's plans submitted to demonstrate prima facie network adequacy as part of the solicitation process. Plans that are awarded contracts will be required to submit complete network information. Credentialing files will be reviewed for completeness and accuracy by the state during the plan readiness process and during annual monitoring thereafter. The state has developed performance measures and remediation strategies to ensure corrective action will be taken by the plans if improper credentialing is found.

_____ This is an existing program that will be expanded during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

- X If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.
 - i. X Potential enrollees will have 30 days to choose a plan.
 - ii. X Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

The Agency will send affected Medicaid recipients a notice, followed by an enrollment information package, including important action dates prior to each region's transition date. Whether recipients are currently enrolled in a managed care plan or not they will be directed to review the materials and receive telephonic or face-to-face choice counseling to choose the best plan for their needs. The Agency will automatically enroll recipients into an LTC plan if they do not select a plan of their own volition based on the following criteria:

- (a) *Whether the plan has sufficient network capacity to meet the needs of the recipients.*
Considerations include, but are not limited to, the plan's enrollment capacity; whether the plan has established provider contracts with all required providers in the region (i.e., nursing facilities, hospices, aging services providers that have recently served recipients); network adequacy standards including whether

the plan, at a minimum, has two providers for each service type per county; and, for nursing facilities, assisted living facilities, and adult day health care centers, the geographical proximity of the plan's providers to the recipient.

(b) Whether the recipient is enrolled in that plan through the Nursing Home Diversion waiver.

The state is also considering whether we can make an assignment based on the recipient's key care providers being part of a plan's network. While the state can readily determine this information for transitioning recipients in fee-for-service waivers, it is exploring if, and how, it can reliably collect this information for transitioning recipients who are already in managed care.

A recipient who is automatically enrolled in a plan retains the right to change plans during open enrollment and for cause thereafter.

Once a recipient has chosen or is assigned to a managed care plan, the Agency will notify the plan of the new enrollee. Managed care plans are required to send new enrollees a welcome enrollment package by the first day of enrollment or within five calendar days following receipt of the enrollment file from Medicaid or its agent, whichever is later. Managed care plans are required to continue a new enrollee's services for up to sixty days after enrollment, or until they complete the required case management and care plan assessments.

++Irrespective of whether a recipient has transitioned from another plan or not, their care will continue unabated until the new managed care plan has finished its required assessments. Recipients retain their right to a Fair Hearing to challenge plan determinations and their right to continue services at their current level until the appeal is exhausted. DOEA will audit care plans that are reduced as a result of the new managed care plan's assessments.

All current Nursing Home Diversion waiver managed care plans are required to develop transition plans for their enrollees on the basis of:

- If the plan is awarded a contract under the long-term care managed care program.*
- If the plan is not awarded a contract and will continue to serve enrollees until the transition date in all regions served.*
- If the plan is not awarded a contract and will end its contract early and stop serving enrollees prior to the date of transition.*

DOEA will assess these transition plans to determine whether they meet the extensive transition plan requirements contained in its current provider contract and to determine which of the three options above the plan intends to pursue.

___ The State automatically enrolls beneficiaries

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ___ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

X The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process: *This process is completed on a case-by-case basis and approved by state Medicaid staff.*

When a Medicaid recipient contacts the state's contracted enrollment broker to request an exemption from enrollment, the enrollment broker will alert the Agency for Health Care Administration and refer this request to the Agency. The Agency will work with the individual and the individual's managed care plan to try and reach a mutually acceptable solution. If this cannot be achieved, and other available managed care plans in the region cannot meet the individual's specific needs, then the Agency has the ability to instruct the enrollment broker to exempt the individual from enrollment into managed care. Possible circumstances under which an individual might request an exemption from enrollment in the Long Term Care Managed Care Program, could include someone who is residing in a specific nursing facility or who is receiving services from a hospice that is not part of any managed care network in that individual's region.

X The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

X The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or

plan files the request. If determination is not made within this time frame, the request is deemed approved.

- i. X Enrollee submits request to State.
- ii. X Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- iii. X Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request. The State may require enrollees to seek redress through the long-term care plan grievance process except in cases in which immediate risk of permanent damage to the member's health is alleged.

— The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

X The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of 12 months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

Additional "Good Cause" Plan Change Reasons:

- Member enrolled in error
- Member has moved to a different geographic area
- Plan no longer available in the region
- Plan marketing violation
- State-imposed intermediate sanction

— The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

X The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

- i. X MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

Examples of reasons: member death, fraudulent use of beneficiary ID card; beneficiaries moving outside the program's authorized service area; or ineligible for enrollment in managed care. State staff approves these disenrollment requests and monitors plan disenrollments for discriminatory practices.

- ii. X The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. X If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.
- iv. X The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. Assurances.

X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

_____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

X The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs.** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
- b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

X The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

3. **Details for MCO or PIHP programs.**

a. **Direct access to fair hearing.**

_____ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **30** days (between 20 and 90).

The State's timeframe within which an enrollee must file a **grievance** is **365** days.

c. Special Needs

The State has special processes in place for persons with special needs. Please describe.

4. Optional grievance systems for PCCM and PAHP programs. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services. **N/A**

The State has a grievance procedure for its ___ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

- The grievance procedure is operated by:
 - the State
 - the State's contractor. Please identify: _____
 - the PCCM
 - the PAHP.

Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

Specifies a time frame from the date of action for the enrollee to file a request for review, which is: _____ (please specify for each type of request for review)

- ___ Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

- ___ Establishes and maintains an expedited review process for the following reasons: _____. Specify the time frame set by the State for this process _____

- ___ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

- ___ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

- ___ Other (please explain):

F. Program Integrity

1. Assurances.

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

- (1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

- (1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
- (2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
- (3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
- 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
- 3) Employs or contracts directly or indirectly with an individual or entity that is
 - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
 - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

X State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604

Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. **If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.**

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the State will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the State and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The State must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under “Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Monitoring Activity												
Accreditation for Non- duplication												
Accreditation for Participation					X							
Consumer Self- Report data	X	X	X	X	X	X			X	X	X	
Data Analysis (non-claims)	X		X	X	X	X						
Enrollee Hotlines	X				X	X						
Focused Studies												
Geographic mapping										X		
Independent Assessment				X	X							
Measure any Disparities by Racial or Ethnic Groups	X	X			X	X				X	X	
Network				X						X	X	X

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Adequacy Assurance by Plan												
Ombudsman												
On-Site Review	x	X	X	X	X	X	X	X	X	X	X	X
Performance Improvement Projects			X	X			X	X		X	X	
Performance Measures				X			X			X	X	
Periodic Comparison of # of Providers				X			X			X		
Profile Utilization by Provider Caseload				X			X			X		
Provider Self-Report Data		X			X						X	
Test 24/7 PCP Availability												
Utilization Review				X	X	X	X	X		X	X	X
Other: Desk	X	X	X	X	X	X	X	X	X	X	X	X

Evaluation of Quality	Quality of Care	
	Provider Selection	
	Coverage/ Authorization	
Evaluation of Access	Coordination/ Continuity	
	PCP/Specialist Capacity	
	Timely Access	
Evaluation of Program Impact	Grievance	
	Information to Beneficiaries	
	Program Integrity	
	Enroll Disenroll	
	Marketing	
	Choice	
Monitoring Activity		
		Reviews

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

- a. Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

- NCQA
 JCAHO (Joint Commission)
 AAAHC
 Other (please describe)

The State does not currently allow deeming.

- b. Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

- NCQA
 JCAHO
 AAAHC
 Other (please describe)

Utilization Review Accreditation Commission/American Accreditation Healthcare Commission (URAC/AAHC)

Applicable Program: LTC Managed Care

Personnel Responsible: Long Term care Managed Care plans

Detailed Description of Strategy/Yielded Information:

Each Long-term care plan is to be accredited (by one of the state approved accrediting organizations checked above) within 18 months from the initial contract award date.

Frequency of Use: The Long-term care plan must submit documentation of accreditation to the state upon receipt of accreditation and at the end of each accreditation review.

- c. X Consumer Self-Report data
 X CAHPS (please identify which one(s))
 ___ State-developed survey
 ___ Disenrollment survey
 ___ Consumer/beneficiary focus groups
 X Other-Consumer Complaint Resolution

The state will use the CAHPS Health Plan Survey to ask enrollees about their recent experience with health plans and services.

c.1 Applicable Program: LTC Managed Care

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: CAHPS – Plans will be required to participate in an independent survey of member satisfaction, currently the Consumer Assessment of Health Plans Study Survey (CAHPS), conducted by the State on an annual basis. The plans use the results of the survey to develop and implement plan-wide activities designed to improve member satisfaction. Activities include, but are not limited to, analyses of the following: formal and informal member complaints, claims timely payment, disenrollment reason, policies and procedures, and any pertinent internal improvement plan implemented to improve member satisfaction.

Frequency of Use: The CAHPS is conducted annually. State staff review the CAHPS survey results and if there are any deficiencies, a corrective action plan is required. Activities pertaining to improving member satisfaction resulting from the survey must be reported to the State on a quarterly basis within 30 days after the end of a reporting quarter. The state agency reviews the quarterly improvement satisfaction reports. If there is a deficiency, then a corrective action plan is required.

c.2 Applicable Program: LTC Managed Care

Personnel Responsible: Long Term Managed Care plans

Detailed Description of Strategy/Yielded Information: Long Term Managed Care plan marketing and pre-enrollment complaints – The Long Term Managed Care plans develop and maintain procedures to log and resolve marketing and pre-enrollment complaints, including procedures that address the resolution of repeated complaints against marketing staff. The procedures contain a provision that a plan employee outside the marketing department must handle the resolution of all repeated marketing complaints.

Frequency of Use: Marketing and pre-enrollment complaints are reviewed and investigated as they are reported to the State by Medicaid recipients. In addition, the plans' marketing and pre-enrollment complaints log is reviewed during the comprehensive plan survey process every year.

- d. x Data Analysis (non-claims)
 x Denials of referral requests
 x Disenrollment requests by enrollee
 x From plan

- From PCP within plan
- Grievances and appeals data
- PCP termination rates and reasons
- Other (please describe)

Applicable Program: LTC Managed Care

Personnel Responsible: State staff /Long Term Managed Care plans

Detailed Description of Strategy/Yielded Information: LTC Managed Care Grievance System Survey - The Long Term Managed Care plans are required to have a grievance system in place for enrollees that include a grievance process, an appeal process, and access to the Medicaid Fair Hearing system. The Long Term Managed Care plans must develop, implement and maintain a grievance system as set forth under contract and that complies with federal laws and regulations, including 42 CFR 431.200 and 438, Subpart F. The grievance system must include procedures for ensuring persons with special needs are able to access the system. The MCO grievance system is monitored by the State through on-site surveys, desk reviews and reports to the State. The on-site survey looks at a sample of the grievance files. This survey is performed with each contract period. The desk review monitors the policies and procedures and member materials. The desk review is performed during each contract period; additional desk reviews are conducted as needed due to contract changes. The LTC managed care contract will require quarterly reporting of new and outstanding grievances.

Frequency of Use: The on-site surveys and desk reviews are conducted annually. The Long Term Managed Care plans report new and outstanding grievances quarterly to the State.

- e. Enrollee Hotlines operated by State

Applicable Program: LTC Managed Care

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: The State provides a toll-free telephone system for consumers to call in order to file complaints, receive publications, information and referral numbers.

Frequency of Use This system can be accessed between the hours of 8:00 a.m. and 6:00 p.m. eastern time Monday through Friday.

- f. Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

- g. Geographic mapping of provider network

Applicable Program: LTC Managed Care

Personnel Responsible: State staff /Long Term Managed Care plans

Detailed Description of Strategy/Yielded Information: Availability/Accessibility

of services for Long Term Managed Care plans- The Long Term Managed Care plans provide geographic mapping of the provider networks prior to executing the contract, when an expansion is requested, and during a comprehensive on-site survey. The provider directories are also reviewed each contract year.

Frequency of Use: Prior to enrollment implementation, annually, or more frequently when necessary.

- h. X Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

The independent assessment of the Long Term Care Managed Care Program will include information on the impact, quality, and cost effectiveness of the waiver program.

Applicable Program: LTC Managed Care

Personnel Responsible: Contracted Independent Assessor

Detailed Description of Strategy/Yielded Information: Independent assessment of the access will include a comparison of number and types of Medicaid LTC providers participating in each plan before and after the waiver.

Frequency of Use: Every 5 years for first two waiver periods.

- i. X Measurement of any disparities by racial or ethnic groups

Applicable Program: LTC Managed Care

Personnel Responsible: Long-term care plans

Detailed Description of Strategy/Yielded Information:

As part of the Independent Assessment mentioned in “h” above, measurement of racial and ethnic group disparities are reported.

Frequency of Use: Every 5 years for first two waiver periods, or more frequently as necessary.

- j. X Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

Applicable Program: LTC Managed Care

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information:

Availability/Accessibility of Services – Long Term Care Managed Care plans are required to provide adequate assurances that the plan, with respect to the service area, has the capacity to serve the expected enrollment in such service area. The plans are required to offer an appropriate range of services and access to health care services for the populations expected to be enrolled in such service area and maintains sufficient number, mix, and geographic distribution of providers of services. The State conducts on-site surveys annually to ensure compliance.

Frequency of Use: Provider directories are reviewed yearly and when necessary to determine minimum network standards.

k. X Ombudsman:

Brief description of the Independent Consumer Support Program (ICSP):

The ICSP is a coordinated effort by the Florida Department of Elder Affairs' (DOEA) Bureau of Long-Term Care and Support working with the statewide Long-Term Care Ombudsman Program (LTCOP) and local Aging and Disability Resources Centers (ADRCs). DOEA has administered Medicaid managed long-term care programs for more than 10 years and its role has included assisting enrollees in understanding coverage models and resolving problems and complaints regarding services, coverage, access and consumer rights within the managed care environment.

With the creation of the Statewide Medicaid Managed Long-Term Care Program (SMMC-LTC) in 2011, the Legislature established DOEA as the independent quality and monitoring oversight entity that will operate as an intermediary between the State and its Medicaid beneficiaries, contracted health plan and aging network providers to ensure the system is responsive to service issues and quality of care. DOEA will build on its existing complaint resolution infrastructure to develop an even stronger independent consumer support process to serve Medicaid enrollees utilizing managed long-term care services in both nursing facility and community-based settings.

See Attachment A for a complete description of the ICSP.

l. X On-site review

l. 1. Applicable Program: LTC Managed Care

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information:

On-site reviews – The comprehensive survey encompasses the various areas of compliance authorized by 42 CFR 438, Title XIX of the Social Security Act (including sections 1915b and 1915c), and Florida statutes. The scope of services and work to obtain compliance by all Florida Long Term Care Managed Care plans are reviewed and monitored using the comprehensive survey tools to identify any non-compliant areas. If non-compliant areas are identified, corrective action is required within a given time frame. This is reviewed and implementation is required as appropriate to the area identified as non-compliant. If non-compliance is not corrected in the given time frame, sanctions or fines may result from the findings of this survey process. The measures of compliance in the Florida LTC Managed Care program are detailed in the comprehensive survey to cover all sources of requirements. This survey is also used when a new plan signs a Medicaid contract. All comprehensive surveys are completed on site. Various components of the comprehensive surveys can also be completed by desk review prior to the on-site survey.

The State conducts annual on-site reviews of the Long Term Care Managed Care plans for assessment of compliance with contract requirements. The State monitors the

contractor on the quality, appropriateness, and timeliness of services provided under the contract. The State inspects any records, papers, documents, facilities, and services, which are relevant to the

contract. The contractor provides reports, which are used to monitor the performance of the contractual services. The comprehensive review is a focus on the main provisions of the contract including: Grievance System, Member Services, Quality Improvement, Utilization Management, Selected Example of Medical Records, Case Management, Credentialing of Providers, and Staffing Requirements. Minimally, the following components of the above stated provisions are reviewed:

- Administration and Management Policy and Procedures
- Staffing
- Disaster Plan
- Minority Provider Retention and Recruitment Plan
- Insurance documents
- Member Identification Card
- Credentialing and Re-credentialing Policy and Procedures
- Credentialing files
- Medical Record Requirements Policy and Procedures
- Member Handbook
- Provider Directories
- Key Personnel files
- Quality Improvement Policy and Procedures
- Member Services and Enrollment Policy and Procedures
- Utilization Management Policy and Procedures
- Case Management/Continuity of Care Policy and Procedures
- Marketing Policy and Procedures
- Marketer Training
- Marketing Plan
- Pre-enrollment Form
- Request for Enrollment Form
- Sample Agent Application
- Provider Networks
- Provider Site Visit Form
- Grievance and Appeals Policy and Procedures
- Grievance and Appeals Letters
- Quality Benefit Enhancements
- Organization Chart
- Information Systems
- Model Subcontracts
- Prompt Payment Documentation
- Fraud and Abuse Prevention and Reports
- Frequency of Use:** Annually

1.2 Applicable Program: LTC Managed Care
Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: Long Term Care Managed Care plan Disenrollment Summary – State staff will perform site reviews of recipient disenrollment files to assess the accuracy of these reports and to review the documentation of reasons for disenrollment. These reviews will include a review of disenrollment due to patient deaths and disenrollments for reasons reported as other.
Frequency of Use: Annually

- m. X Performance Improvement projects [**Required** for MCO/PIHP]
 X Clinical
 X Non-clinical

Applicable Program: LTC Managed Care

Personnel Responsible: State staff /Long Term Managed Care plans

Detailed Description of Strategy/Yielded Information: Quality of care studies – Long Term Managed Care plans must perform at least two, Agency-approved, quality of care studies. These clinical and non-clinical studies are compliant with 42 CFR 438.240. In addition, the quality of care studies: target specific conditions and health service delivery issues for focused individual practitioner and system-wide monitoring and evaluation; use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions; use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered; implement system interventions to achieve improvement in quality; evaluate the effectiveness of the interventions; plan and initiate activities for increasing or sustaining improvement and monitor the quality and appropriateness of care furnished to enrollees with special health care needs. State staff reviews the studies according to 42 CFR 438.240 and the Florida LTC Managed Care contract. If plans are out of compliance, then corrective action is required.

Frequency of Use: Quarterly over each contract period.

- n. X Performance measures [**Required** for MCO/PIHP]
 Process
 Health status/outcomes
 Access/availability of care
 Use of services/utilization
 Health plan stability/financial/cost of care
 Health plan/provider characteristics
 Enrollee safety and welfare

n.1 **Applicable Program:** LTC Managed Care

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: Long-term Managed Care Plan quality and performance measures reviews are performed at least once annually, at dates to be determined by the State. On-site monitoring activities include, but are not limited to, inspection of contractor’s facilities; review of staffing patterns and ratios; audit and/or review of all records developed under this contract, including clinical and financial records; review of management information systems and

procedures developed under the contract; desk audits of information and outreach provided by the contractor; review of any other areas or materials relevant to or pertaining to the contract.

Frequency of Use: Annually

n.2 Applicable Program: LTC Managed Care

Personnel Responsible: State staff / Long Term Managed Care Plans

Detailed Description of Strategy/Yielded Information: Long Term Managed Care Plan staff licensure - The Long Term Managed Care plans are responsible for assuring that all persons, whether they be employees, agents, subcontractors or anyone acting for or on behalf of the plan, are properly licensed under applicable State law and/or regulations and are eligible to participate in the Medicaid program.

The state will perform a readiness review of each plan prior to approving the plan for operation. As a part of this review, the state will review a sample of plan network files to assure that providers are properly licensed and eligible to participate in Medicaid. If the sample shows that the plan is not in compliance, the state will require the plan to correct the problem, then will re-review and take a new sample. This process will continue until the plan can demonstrate full compliance. After implementation of the Long Term Care Managed Care Program, the state will monitor each plan at least annually and will review a representative sample of participating providers to ensure that all persons are properly licensed and eligible to participate in Medicaid.

Frequency of Use: Annually

n.3 Applicable Program: LTC Managed Care

Personnel Responsible: State staff / Long Term Managed Care Plans

Detailed Description of Strategy/Yielded Information: Quality Improvement - The plans have a quality improvement program with written policies and procedures that ensure enhancement of quality of care and emphasize quality patient outcomes. Please see response to "m" above.

Frequency of Use: Quarterly during contract period

n.4 Applicable Program: LTC Managed Care

Personnel Responsible: State staff / Long Term Managed Care Plans

Detailed Description of Strategy/Yielded Information: Independent Member Satisfaction Survey - The Long Term Managed Care Plan participates in enhanced managed care quality improvement including at least the following: participates in an independent survey of member satisfaction, currently the Consumer Assessment of Health Plans Study

survey (CAHPS), conducted by the State on an annual basis in accordance with Section 409.912(29)(e), F.S.

Frequency of Use: Annually

n.5 Applicable Program: LTC Managed Care

Personnel Responsible: State staff / Long Term Managed Care Plans

Detailed Description of Strategy/Yielded Information:

Availability/Accessibility of Services- See response to “j” above.

Frequency of Use: Provider directories are reviewed yearly or more frequently when necessary.

- o. X Periodic comparison of number and types of Medicaid providers before and after waiver:

Prior to implementation of the Long Term Care Managed Care Program, each contracted managed care plan’s network of providers will be assessed for adequacy and readiness. Periodically after implementation, all managed care plans will be required to submit a report of their provider network, to ensure that numbers and types of providers remain adequate. If the state determines that provider networks have not remained adequate, the state will look for specific trends that might impact access to services.

- p. X Profile utilization by provider caseload (looking for outliers)

The state will perform periodic desk reviews and annual on-site reviews to determine if outliers exist for any of the providers. Monitoring for outliers will include periodic reviews of client assessments, plans of care, and service utilization reports. The state will look for trends in complaints, grievances, or fair hearing requests. Service utilization patterns before and after program implementation will be closely monitored to ensure that medically necessary services continue to be provided.

- q. X Provider Self-report data

 X Survey of providers

 X Focus groups

q.1 Applicable Program: LTC Managed Care

Personnel Responsible: State staff /Long Term Managed Care plans

Detailed Description of Strategy/Yielded Information: Marketing and Pre-enrollment Materials - For each new contract period, each plan submits to the State for written approval its marketing strategy and all marketing and pre-enrollment materials no later than 60 calendar days prior to contract renewal, and for any changes in marketing and pre-enrollment materials during the contract period, no later than 60 calendar days prior to implementation. The marketing materials must be distributed in the plan’s entire service area. To announce a specific event, the plan submits a request to market pursuant to section 30.2.2.1, Approval Process, and include the announcement of the event that will be given out to the public.

Frequency of Use: On-going

q.2 Applicable Program: LTC Managed Care

Personnel Responsible: State staff /Long Term Managed Care Plans

Detailed Description of Strategy/Yielded Information: Approval Process - Health Fairs and public events are approved or denied by the State using the following process: Each plan submits its bimonthly marketing schedule to the State, two weeks in advance of each month. The marketing schedule may be revised if a plan provides notice to the State one week prior to the public event or the health fair. The State may expedite this process as needed.

Frequency of Use: Monthly

q.3 Applicable Program: LTC Managed Care

Personnel Responsible: State staff /Long Term Managed Care Plans

Detailed Description of Strategy/Yielded Information: Marketing Representatives - Each plan is required to register each marketing representative with the State. The registration consists of providing the State with the representative's name; address; telephone number; cellular telephone number, DOI license number; the names of all Medicaid plans with which the representative was previously employed; and the name of the Medicaid plan with which the agent is presently employed. Each plan provides the State on a monthly basis, information on terminations of all marketing representatives. Each plan maintains and makes available to the State upon request evidence of current licensure and contractual agreements with all marketing representatives used by the plan to recruit recipients.

Frequency of Use: Monthly and as needed.

r. _____ Test 24 hours/7 days a week PCP availability

s. X Utilization review (e.g. ER, non-authorized specialist requests)
Contracted managed care plans will be required to submit periodic service utilization reports to be monitored by desk review and on-site. The state will monitor whether contracted plans maintain and adhere to proper utilization review criteria, whether they apply them consistently, and if services are denied, whether enrollees are provided with appropriate and timely notice, including grievance and appeal rights.

t. X Other: (please describe)

Applicable Program: LTC Managed Care

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information: Desk review – Some desk reviews are accomplished on an *as needed* basis. The State determines that there is a significant non-compliance issue with a PIHP that can be resolved by specific information and documentation submitted by the PIHP then a desk review is implemented. Required desk reviews are conducted by using the survey tools.

Frequency of Use: As needed

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

This is a renewal request.

This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:

Confirmation it was conducted as described:

Yes

____ No. Please explain:
Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming three-year waiver period, called Prospective Year 1 (P1), Prospective Year 2 (P2) and Prospective Year 3 (P3). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective three-year period.

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

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

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

Part I: State Completion Section

A. Assurances

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

- Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances:
 c. Stacey Lampkin
 d. Telephone Number: 850-412-4798
 d. E-mail: Stacey.Lampkin@ahca.myflorida.com
 e. The State is choosing to report waiver expenditures based on X date of payment.
 date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test.
Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.

- a. The State provides additional services under 1915(b)(3) authority.
 b. The State makes enhanced payments to contractors or providers.
 c. The State uses a sole-source procurement process to procure State Plan services under this waiver.
 d. Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

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

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

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

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

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

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

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

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

- a. Population in the base year data
 - 1. Base year data is from the same population as to be included in the waiver.
 - 2. Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

The State has utilized the regional phase-in schedule described in Section A, Part I, Section C of the 1915(b) waiver narrative to determine the appropriate member months to include in each quarter. It is anticipated the enrollment of members in the first region will begin between July 1, 2013 and August 1, 2013. The HCBS waiver slots are estimated to increase on average 2-3% annually once all transitions have been completed. For non-HCBS member months, the State has assumed a .5% increase per month to reflect the expected growth in this Medicaid target population and the aging of the Medicaid population.

The membership projections assume enrollment growth at approximately 1.1% per quarter once the phase-in has fully being implemented.

- d. [Required] Explain any other variance in eligible member months from BY to P3: _____

There is no other variance in eligible member months.

- e. [Required] List the year(s) being used by the State as a base year: 2010. If multiple years are being used, please explain: _____
- f. [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period SFY.
- g. [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:

For all Medicaid eligibility Groups (MEGs), the base data is derived from the SFY 2010 historical expenditures on services covered under the waiver and pulled directly from the State's MMIS.

For Conversion or Renewal Waivers:

- a. ___ [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. ___ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. ___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

- d. ___ [Required] Explain any other variance in eligible member months from BY/R1 to P2: _____
- e. ___ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

- a. **X** [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

All services outlined on page 25 of the 1915(b) pre-print under covered services have been included in the cost effectiveness projections.

At this time, no FFS impacted services have been included in the 1915(b) waiver because a separate capitated program including all services excluded from this capitated program is expected to begin during waiver year 2.

For Conversion or Renewal Waivers:

- a. ___ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**:
- b. ___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single

beneficiary, please document how all costs for waiver covered individuals taken into account:

G. Appendix D2.A - Administration in Actual Waiver Cost

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

For Initial Waivers:

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

The State will have additional administrative costs under this waiver program as listed in the chart below. These costs will be funded through savings generated from effective management of nursing facility State Plan Services under managed care. The State anticipates the implementation of this managed care program will generate savings due to effective management of nursing home services (-.2% adjustment has been placed in the appendices). The State is assuming these savings will provide funds for the additional administrative responsibilities of this waiver program including EQRO, independent assessment, and actuarial development of capitated rate. The administrative adjustment, as well as the managed care efficiency adjustment is reflected in Appendix D5.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
EQRO (assumes 10 plans)	\$1,200,000 or \$1.64 PMPM in P1 prorated for a partial calendar year) \$2,625,000 or \$2.03PMPM in P2	5% annual inflation beginning in P2 for each year of the waiver or \$131,250	P1 \$1,200,000 (\$1.64 PMPM) P2 \$ 2,625,000 (\$2.03 PMPM) P3 \$ 2,756,250 (\$2.04 PMPM)
Independent Assessment	\$145,000 or \$.11 PMPM in P2	One time adjustment in P2 of waiver	P1 \$0 (\$0.00 PMPM) P2 \$145,000 (\$0.11 PMPM)

		period so no inflation	P3 \$0 (\$0.00 PMPM)
Actuary	\$769,060 or \$1.05 in P1 PMPM	5% annually for each year of the waiver or \$78,830 PMPMs decrease from P1 to P2 due to geographical phase-in and ramp up in member months	P1 \$769,060 (\$1.05 PMPM) P2 \$807,513 (\$0.62 PMPM) P3 \$847,889 (\$0.63 PMPM)
Total	\$1,969,060 or \$2.69 PMPM in P1	5% annually for each year of the waiver or \$210,080	P1 \$1,969,060 (\$2.69 PMPM) P2 \$3,577,216 (\$2.77 PMPM) P3 \$3,604,139 (\$2.66 PMPM)

The allocation method for either initial or renewal waivers is explained below:

- a. ___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*
- b. X The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

The State allocated administrative costs to this LTC PIHP waiver based on the percentage of total Medicaid expenditures related to the services covered under the waiver. For this waiver, 17.1% of total Medicaid service expenditures are assumed to be related to the covered services. The resulting BY administrative expense is \$12.49 PMPM, reflected on Appendix D.3.

- c. ___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

- a. ___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

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

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
Total			

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State’s Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period

b. ___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

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

Basis and Method:

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

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

1. ___ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.
 - i. Document the criteria for awarding the incentive payments.
 - ii. Document the method for calculating incentives/bonuses, and

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

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 through P3. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P3). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be**

taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

1. [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*). **The actual trend rate used is: 9% from SFY 2010 to YTD SFY 2011 for HCBS services and 0% for nursing facility and hospice services.** Please document how that trend was calculated:

To develop trend from SFY 2010 to the present, the State's expenditure reports summarizing Medicaid services for nursing home, hospice and home and community based service expenditures from the BY (SFY 2010) through the most recently available data were reviewed. This data exhibited a flat trend from SFY 2010 to YTD for nursing facility and hospice and a 9% trend for HCBS services.

2. [Required, to trend BY to P1 through P3 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) (*i.e., trending from present into the future*).
- i. State historical cost increases. Please indicate the years on which the rates are based: base years SFY 2008-2011 In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

The State's expenditure reports and historical FFS data were the primary sources for determining trend for the prospective period from July 2008-2010 through the end of the waiver period. The state considered historical year over year trends in developing the trend estimate, the state considered changes to the FFS Medicaid program. The actual inflation experienced by Florida HCBS populations since 2008 to present have ranged from 5.3% to 19.6% while the actual inflation experienced by non-HCBS populations ranged from 0.9% to 15%.

For the prospective time periods, the state assumed a 7% trend. The average annual trend from BY to P1 was 7.6% for HCBS MEGS and 5.0% for non-HCBS population MEGS. Column J of Appendix D.5 reflects the annualized trend. The trend from P1 to

P2 and P2 to P3 was assumed at the projected average of 7% based upon the historical averages and fluctuations experienced by this population.

The State was careful not to duplicate the impact of the program changes, including the managed care efficiency adjustment for implementing capitated managed care incenting fewer nursing home admissions and trend assumptions.

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

3. **X** The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 through P3.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

Utilization trends are not developed separately from unit cost trends.

ii. Please document how the utilization did not duplicate separate cost increase trends.

Utilization trend is considered in the State's overall analysis of trend. Separate trends are not developed for utilization.

b. **X** **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1, P2 and P3 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes

in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

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

1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. An adjustment was necessary. The adjustment(s) is(are) listed and described below:
 - i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Determine adjustment for Medicare Part D dual eligibles.**
 - E. ___ Other (please describe):
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ Changes brought about by legal action (please describe): For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
 - iv. ___ Changes in legislation (please describe): For each change, please report the following:

- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
- B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
- C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
- D. ___ Other (please describe):
- v. X Other (please describe):
- A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
- B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
- C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
- D. X Other (please describe):

The State projects managed care efficiency adjustments equal to -0.2% of nursing facility costs due to the management of institutional care by the capitated vendors.

Under the proposed program, the new 1915(c) waiver will subsume four existing waivers, one of which includes the Nursing Home Diversion Waiver. This program is offered on a capitated basis and the costs shown in D13 are capitated costs within the base year for the Nursing Home Diversion program.

The State's actuary developed capitated rates on a regional basis to meet the State's program requirement of paying the same rate to the MCOs for the HCBS and Non-HCBS MEGs, which combined represent individuals that meet the nursing facility level of care requirement. However, the original 1915 (b) cost-effectiveness application did not reflect this design because the exact data pull for the rate methodology by region had not been finalized. Several adjustments were therefore necessary to align the waiver cost-effectiveness with the data in the rates certified by the actuary. These included:

- ***Adjustment due to regional rate differences: The implementation of the phase-in structure in the 1915(b) waiver assumed that all regions would have the same average rate. However, under the final rate structure, regions earlier in the implementation phase have substantially higher rates than the later regions. The waiver implementation phase-in was modified to***

account for the appropriately weighted regional rates by phase-in. Also, during the rate development process, the State updated the implementation date of Region 1 from November 2013 to March 2014 and that change is now reflected in the projected member months in the waiver cost-effectiveness.

- **Case mix changes in the rates due to different member month classifications: Member months of individuals living in each setting were counted differently in the rates than in the waiver. Specifically under the rates, individuals were assigned a living arrangement (Non-HCBS or HCBS) based on the treatment costs for the individual over a period of time rather than whether the individual received an HCBS service each month (a member is Non-HCBS if the individual lived in the nursing for a period of time rather than having not received an HCBS service for the month). This resulted in a different case mix between the MEGs due to the member month reporting change.**
- **Nursing facility rate updates in FFS: A policy that nursing facilities rate paid by MCOs would be set by the State twice a year and capitated rates could also be modified to reflect these institutional rates.**
- **Correction of member month calculations: After further data analysis conducted two years after development of the 1915 (b) waiver, it was found that there should be fewer member months with the same total costs. This results in higher PMPMs and a need for a technical correction to the underlying data in the waiver application.**

The impact of these adjustments is an increase of 14.8% and is shown in column N of appendix D5.

To promote cost-effective care and individual choice of placement under this program, capitated LTC plans will be paid the same capitation rate for the HCBS and Non-HCBS (nursing facility) MEGs who are eligible for the nursing facility level of care. However since this is a 1915 (b) (c) concurrent waiver, the HCBS MEGs, which have members in the 1915 (c) waiver and entitles its members to a differential benefit package from the State Plan, needed to be reported separately on the CMS 64.9 waiver forms. So in order for the waiver reporting to be accurate and to reflect the natural incentives from the blended capitation rate for the nursing facility level of care, a cost-neutral adjustment was

necessary to increase the HCBS MEGs and to decrease the Non-HCBS MEGs. Since the base year costs, reported in D3, varied for the four MEGs, an adjustment was made to reduce the overall trended PMPM for the Non-HCBS MEGs and increase the overall trended PMPM for the HCBS MEGs in P1 to achieve a target combined PMPM weighted by the member months in P that reflects the capitation rates to be paid. Subsequently, in future projection years, the starting point for all MEGS was then the same.

Capitated rates combining Non-HCBS and HCBS member's costs into a single PMPM for individuals meeting nursing facility level of care is a common technique in integrated care models. In a 1915 (b)(c) concurrent waiver where the 1915 (c) waiver enrollees are entitled to a different benefit package than the 1915 (b) only waiver enrollees, the State tracks the differential entitlement through separate MEGs. This ensures that the 1915 (c) enrollees receive the services and appeal rights to which they are entitled, while the same time ensuring that reporting and claiming on the CMC 64.9 waiver forms are correctly attributed in the multiple waivers.

c. X Administrative Cost Adjustment*: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. No adjustment was necessary and no change is anticipated.
2. An administrative adjustment was made.
 - i. FFS administrative functions will change in the period between the beginning of P1 and the end of P3. Please describe:
 - A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

The State administration trend rate was set at 5% prospectively for the remainder of P1 through P3 to project the administrative costs for this waiver. This adjustment is reflected in Column Y of Appendix D5.

As discussed above in part G of this Section, the State also made an adjustment for the anticipated cost of contracts associated with this waiver. This includes additional contracts associated with the PIHP. This adjustment was \$2.65 PMPM and is reflected in Column AB of Appendix D5. The adjustment increased slightly to \$2.77 PMPM in P2 even after a 5% annual inflation due to the ramp-up in member months as a result of the regional phase-in.

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

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual

Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

- d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
1. ___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.
 2. ___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.
 - i. State Plan Service trend
 - A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.
- e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d**, then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.
1. List the State Plan trend rate by MEG from **Section D.I.I.a.** _____
 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____
 3. _____ Explain any differences:
- f. **Graduate Medical Education (GME) Adjustment:** 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.
1. We assure CMS that GME payments are included from base year data.
 2. ___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
 3. ___ Other (please describe): _____
- If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.
1. ___ GME adjustment was made.

- i. ___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
 - ii. ___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. ___ No adjustment was necessary and no change is anticipated.

Method:

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

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5**.

- 1. ___ Payments outside of the MMIS were made. Those payments include (please describe):
- 2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
- 3. X The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

- 1. ___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
- 2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
- 3. X The State has not made an adjustment because the same copayments are collected in managed care and FFS.
- 4. ___ Other (please describe):

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

- 1. ___ No adjustment was necessary and no change is anticipated.

2. ___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

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

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

Basis and method:

1. No adjustment was necessary
 2. Base Year costs were cut with post-pay recoveries already deducted from the database.
 3. ___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
 4. ___ The State made this adjustment:*
- i. ___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
 - ii. ___ Other (please describe):

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

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5.**
2. The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not

prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.

3. ___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under “Other” including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. We assure CMS that DSH payments are excluded from base year data.
2. ___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. ___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. This adjustment is not necessary as there are no voluntary populations in the waiver program.

2. ___ This adjustment was made:

- a. ___ Potential Selection bias was measured in the following manner:
- b. ___ The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2. ___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3. ___ We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.
4. Other (please describe):

Services provided by FQHCs and RHCs will not be paid through the PIHP. Therefore, no adjustment was necessary as these costs are excluded from the base year data used in the waiver.

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. ___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. ___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.
- c. X Not applicable for an initial application utilizing FFS data for projections.

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

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

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation:

Adjustment	Capitated Program	PCCM Program
	PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

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

Documentation of assumptions and estimates is required for this adjustment.

1. ___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
 2. X The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
 3. ___ Other (please describe):
- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5**.

1. X This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
2. ___ This adjustment was made in the following manner:

- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only

include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.

- ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1. No adjustment was made.
2. This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

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

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

1. ___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
2. ___ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated rate setting regulations) (*i.e., trending from present into the future*).
 - i. ___ State historical cost increases. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 - ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
3. ___ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.
 - i. Please indicate the years on which the utilization rate was based (if calculated separately only).
 - ii. Please document how the utilization did not duplicate separate cost increase trends.

- b. ___ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted

above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. ___ An adjustment was necessary and is listed and described below:
 - i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Determine adjustment for Medicare Part D dual eligibles.**
 - E. ___ Other (please describe):**
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

- iv. ___ Changes brought about by legal action (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- v. ___ Changes in legislation (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
- vi. ___ Other (please describe):
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):

- c. ___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.
 - 1. ___ No adjustment was necessary and no change is anticipated.
 - 2. ___ An administrative adjustment was made.

- i. ___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
- ii. ___ Cost increases were accounted for.
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:
 - D. ___ Other (please describe):
- iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
 - B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.
- d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.
 - 1. ___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.

2. [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

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

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

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

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

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

inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. ___ Other (please describe):
 1. ___ No adjustment was made.
 2. ___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
 1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d: D.I.E.c**. Explain the reason for any increase or decrease in member months projections from the base year or over time:

The State has utilized the regional phase-in schedule described in Section A, Part I, Section C of the 1915(b) waiver narrative to determine the appropriate member months to include in each quarter. It is anticipated the enrollment of members in the first region will begin between July 1, 2013 and August 1, 2013. The HCBS waiver slots are estimated to increase on average 2-3% annually once all transitions have been completed. For non-HCBS member months, the State has

assumed a .5% increase per month to reflect the expected growth in this Medicaid target population and the aging of the Medicaid population.

The membership projections assume enrollment growth at approximately 1.1% per quarter once the phase-in has fully being implemented.

D.I.E.d Explain any other variance in eligible member months from BY to P5:

There is no other variance in eligible member months.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

The State did not estimate cost changes separate from the utilization changes. Utilization did not duplicate separate cost increase trends. Utilization trend is considered in the State's overall analysis of trend. Separate trends are not developed for utilization.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

To develop trend from SFY 2009- 2010 to the present, the State's expenditure reports summarizing Medicaid services for nursing home, hospice and home and community based service expenditures from the BY (SFY 2010) through the most recently available date were reviewed. This data exhibited a flat trend from SFY 2010 to YTD for nursing facility and hospice and a 9% trend for HCBS services.

The state's expenditure reports and historical FFS data were the primary sources for determining trend for the prospective period from July 2008-2010 through the end of the waiver period. The state considered historical year over year trends in developing the trend estimate, as well as changes to the FFS Medicaid program. The actual inflation experienced by Florida HCBS populations since 2008 to present have ranged from 5.3% to 19.6% while the actual inflation experienced by non-HCBS populations ranged from 0.9% to 15%.

The average annual trend from BY to P1 was 7.5% for HCBS MEGS and 5.2% for non-HCBS population MEGS.

For the prospective time periods, the state assumed a 7% trend. Column J of Appendix D.5 reflects the annualized trend. The trend from P1 to P2 and P2 to P3 was assumed at the projected average of 7% based upon the historical averages and fluctuations experienced by this population.

The State was careful not to duplicate the impact of the program changes including the managed care efficiency adjustment for implementing capitated managed care incenting fewer nursing home admissions and trend assumptions.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I**.

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.

k. X Ombudsman:

Brief description of the Independent Consumer Support Program (ICSP)

The ICSP is a coordinated effort by the Florida Department of Elder Affairs' (DOEA) Bureau of Long-Term Care and Support working with the statewide Long-Term Care Ombudsman Program (LTCOP) and local Aging and Disability Resources Centers (ADRCs). DOEA has administered Medicaid managed long-term care programs for more than 10 years and its role has included assisting enrollees in understanding coverage models and resolving problems and complaints regarding services, coverage, access and consumer rights within the managed care environment.

With the creation of the Statewide Medicaid Managed Long-Term Care Program (SMMC_LTC) in 2011, the Legislature established DOEA as the independent quality and monitoring oversight entity that will operate as an intermediary between the State and its Medicaid beneficiaries, contracted health plan and aging network providers to ensure the system is responsive to service issues and quality of care. DOEA will build on its existing complaint resolution infrastructure to develop an even stronger independent consumer support process to serve Medicaid enrollees utilizing managed long-term care services in both nursing facility and community-based settings.

See Attachment A for a complete description of the ICSP.

l. X On-site review

l. 1. Applicable Program: LTC Managed Care

Personnel Responsible: State staff

Detailed Description of Strategy/Yielded Information:

On-site reviews – The comprehensive survey encompasses the various areas of compliance authorized by 42 CFR 438, Title XIX of the Social Security Act (including sections 1915b and 1915c), and Florida statutes. The scope of services and work to obtain compliance by all Florida Long Term Care Managed Care plans are reviewed and monitored using the comprehensive survey tools to identify any non-compliant areas. If non-compliant areas are identified, corrective action is required within a given time frame. This is reviewed and implementation is required as appropriate to the area identified as non-compliant. If non-compliance is not corrected in the given time frame, sanctions or fines may result from the findings of this survey process. The measures of compliance in the Florida LTC Managed Care program are detailed in the comprehensive survey to cover all sources of requirements. This survey is also used when a new plan signs a Medicaid contract. All comprehensive surveys are completed on site. Various components of the comprehensive surveys can also be completed by desk review prior to the on-site survey.

The State conducts annual on-site reviews of the Long Term Care Managed Care plans for assessment of compliance with contract requirements. The State monitors the