Florida Medicaid
1915(b) Managed Care Waiver
Long-Term Care Program
(Waiver #FL-17)

Effective Dates: 12/28/16 – 12/27/21

Submitted June 17, 2016
Re-Submitted August 19, 2016

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
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<td>CMS Network</td>
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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 renewal 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

___ Amendment request for existing waiver, which modifies Section/Part

___ Replacement pages are attached for specific Section/Part being amended

___ Document is replaced in full, with changes highlighted and as noted in Summary of Changes document submitted with this amendment to phase out the waiver.

X 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.

Section A is ___ Replaced in full

X The state assures the same Program Description from the previous waiver period was used, with the exception of changes noted in the Summary of Changes document. The summary lists changes to Section A. The majority of changes are technical and made to update the waiver.

Section B is ___ Replaced in full

X The state assures the same Monitoring Plan from the previous waiver period was used, with exceptions noted in the Summary of Changes document. The summary lists the changes to Section B. A majority of the changes are technical and made to update the waiver.

Section C is ___ Replaced in full

X The state assures the same Monitoring Activity from the previous waiver period was used, with exceptions noted in the Summary of Changes document. The summary lists the changes to Section C. A majority of the changes are technical and made to update the waiver.

Section D is ___ Replaced in full

X The state assures the same cost-effectiveness methodology was used
from the previous waiver period for this amendment. The entire cost-effectiveness was updated to reflect the phasing out of the waiver.

**Effective Dates:** This waiver renewal is requested for a period of 5 years; effective December 28, 2016 and ending December 27, 2021. (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 renewal section 1915(c) waiver also being submitted to CMS for approval.

**State Contact:** The State contact person for this waiver is **Heather Morrison**

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Section A: Program Description

Part 1: 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 April 27, 2016, are included in Attachment E.

The State has not received any comments from any of the tribes notified of the development of the waiver renewal application.

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 1915(b) and 1915(c) waiver renewal applications to the Centers for Medicare & Medicaid Services (CMS) to operate the Florida Long-Term Care Managed Care Program mandated by the Florida Legislature in 2011. Section 409.978, Florida Statutes, establishes 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 has implemented and administers 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 allow the State to require eligible Medicaid recipients to receive 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 is determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Bureau. Medicaid recipients eligible for the Florida Long-Term Care Managed Care Program have a choice of plans and may select any plan available in their region. The State is divided into eleven regions, each of which is required to have a specified number of long-term care plans.

The State transitioned recipients into the LTC program beginning August 2013 through March 2014. AHCA, together with DOEA, monitor plan performance, measure quality of service delivery, identifies and remediates any issues, and facilitates working relationships between LTC plans and providers. Through these efforts, the State provides incentives to serve recipients in the least restrictive setting and eligible recipients receive improved access to care and quality of care.

Florida finalized program contracts in June 2013 and submitted the documents to the Centers for Medicare and Medicaid Services (CMS) for review and approval. Later contract amendments
were also submitted to CMS and approved as well.

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. _X_ 1915(b)(l) - 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)(l) or (b)(4) authority.

   d. _X_ 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

 X MCO
 X 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. ___ 1902(a)(l) - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State.

   a. _X_ 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.

b. _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.

c. ___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).

d. ___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. _X_ 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. _X_ 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.

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

      ___ 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 MCP; procurement for PIHP, etc):

___ Competitive bid 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.

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

In each of the 11 geographic regions of the State, enrollees have a choice of at least two PIHPs. The State contract 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)(I)(ii)):

4. 1915(b)(4) Selective Contracting

- [___] Beneficiaries will be limited to a single provider in their service area (please define service area).
- [X] 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.

- [X] Statewide -- all counties, zip codes, or regions of the State
- [___] 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.
<table>
<thead>
<tr>
<th>Region</th>
<th>County</th>
<th>Type of Program (PCCM, MCO, PIHP, or PAHP)</th>
<th>Name of Entity (for MCO, PIHP, PAHP)*</th>
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<tbody>
<tr>
<td>Region 1</td>
<td>Escambia, Santa Rosa, Walton, and Okaloosa</td>
<td>MCO</td>
<td>• Humana American Eldercare, Inc.,</td>
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<td>• Sunshine State Health Plan Inc.</td>
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<td>Region 2</td>
<td>Holmes, Washington, Jackson, Leon, Gadsden, Liberty, Calhoun, Franklin Wakulla, Jefferson, Madison, Gulf, Bay, and Taylor</td>
<td>MCO</td>
<td>• Humana American Eldercare, Inc.,</td>
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<td>• UnitedHealthCare of Florida, Inc.</td>
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<td>Region 3</td>
<td>Hamilton, Suwannee, Columbia, Union, Gilchrist, Alachua, Marion, Lake, Sumter, Levy, Dixie, Lafayette, Bradford, Citrus, Hernando, and Putnam</td>
<td>MCO</td>
<td>• Humana American Eldercare, Inc.,</td>
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<td>• Sunshine State Health Plan, Inc.</td>
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<td>• UnitedHealthCare of Florida, Inc.</td>
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<td>Region 4</td>
<td>Baker, Nassau, Duval, Flagler, Clay, St. Johns, and Volusia.</td>
<td>MCO</td>
<td>• Humana American Eldercare, Inc.</td>
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<td>• UnitedHealthCare of Florida, Inc.</td>
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<td>Region 5</td>
<td>Pinellas and Pasco</td>
<td>MCO</td>
<td>• Humana American Eldercare, Inc.,</td>
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<td>• Sunshine State Health Plan, Inc.</td>
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<td>• UnitedHealthCare of Florida, Inc.</td>
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<td>• Molina Health Care of Florida, Inc.</td>
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<td>Region 6</td>
<td>Hillsborough, Manatee, Polk, Hardee, and Highlands</td>
<td>MCO</td>
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<td>• UnitedHealthCare of Florida, Inc.</td>
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<td>• Coventry Health Care of Florida, Inc.</td>
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<td>• Molina Health Care of Florida, Inc.</td>
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<td>Region 7</td>
<td>Orange, Osceola, Brevard, and Seminole</td>
<td>MCO</td>
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<td>• Coventry Health Care of Florida, Inc.</td>
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<td>Region 8</td>
<td>Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota</td>
<td>MCO</td>
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<td>• UnitedHealthCare of Florida, Inc.</td>
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<td>Region 9</td>
<td>Okeechobee, Indian River, St. Lucie, Martin and Palm Beach</td>
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<td>• Sunshine State Health Plan, Inc.</td>
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<td>• Amerigroup Florida, Inc.</td>
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<td>Region 11</td>
<td>Miami-Dade and Monroe</td>
<td>MCO</td>
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Humana acquired American Eldercare and began operating its LTC plan as Humana American Eldercare in July 2015.
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.
   
   _X_ 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.
   
   _X_ 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 Section1902(a)(lO)(E))

__**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 individuals with Intellectual Disabilities (ICF/IID)-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.

*This waiver serves Medicaid participants enrolled in the Medicaid Managed Medical Assistance Program.

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

Participants in the Long-term Care Waiver can be enrolled only in this program for their HCBS services.
Age appropriate enrollees in the Developmentally Disabilities Individual Budgeting Waiver, Traumatic Brain and Spinal Cord Injury Waiver, Project AIDS Care Waiver, Model Waiver, Adult Cystic Fibrosis, and Familial Dysautonomia Waiver are excluded from the Long-term Care Waiver unless they disenroll from their current waiver and request enrollment in the Long-term Care 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.

___SCIDP 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; and
- 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.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility Services</td>
<td>Intermittent and Skilled Nursing</td>
</tr>
<tr>
<td>Assisted Living Services</td>
<td>Medication Administration</td>
</tr>
<tr>
<td>Caregiver Training</td>
<td>Medication Management</td>
</tr>
<tr>
<td>Adult Day Health Care</td>
<td>Nutritional Assessment and Risk Reduction</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Respite Care</td>
</tr>
<tr>
<td>Home Accessibility Adaptation</td>
<td>Transportation</td>
</tr>
</tbody>
</table>
Although the waiver renewal application requests the removal of the Structure Family Caregiving service, enrollees can receive the service as a downward substitution service for nursing facility care. Home health was previously listed in error as a covered service.

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. 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 the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which 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
- 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.

  X Family planning services are not included under the waiver.

  ___ Other (please explain):

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.

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:
Part 2: 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.

   X. The State assures CMS that it complies with section 1932(c)(l)(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 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)(l)(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 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 beneficiaries normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

      – PCPs (please describe):
      – Ancillary providers (please describe):
      – Dental (please describe):
      – Hospitals (please describe):
      – Mental Health (please describe):
      – Pharmacies (please describe):

      – Substance Abuse Treatment Providers (please describe):
      – 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.

- PCPs (please describe):
- Specialists (please describe):
- Ancillary providers (please describe):
- Dental (please describe):
- Mental Health (please describe):
- Substance Abuse Treatment Providers (please describe):
- Urgent care (please describe):
- 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.

- PCPs (please describe):
- Specialists (please describe):
- Ancillary providers (please describe):
- Dental
- Mental Health (please describe):
- Substance Abuse Treatment Providers (please describe):
- Other providers (please describe):
- Other Access Standards (please describe)

**d. 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 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 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 to 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 an 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 to 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.

<table>
<thead>
<tr>
<th>Number of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
</tr>
<tr>
<td>Pediatrics</td>
</tr>
<tr>
<td>Internist</td>
</tr>
<tr>
<td>RHCs</td>
</tr>
<tr>
<td>Nurse Midwives</td>
</tr>
<tr>
<td>Additional Types of Providers to be in PCCM</td>
</tr>
</tbody>
</table>

*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.

<table>
<thead>
<tr>
<th>PCP to Enrollee Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area (City/County/Region)</td>
</tr>
</tbody>
</table>

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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 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) plans that qualify as PIHPs. Primary, acute and behavioral health care services are not covered and are the responsibility of Medicare for dual eligibles and the Managed Medical Assistance Program managed care plans for other Medicaid recipients. The LTC plans are required to coordinate with the Managed Medical Assistance managed care plans.
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 MCOIPIHP/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 MCOIPIHP/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 MCOIPIHPIPAHP 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 MCOIPIHP/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 to 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 I915(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.
Part 3: Quality

1. Assurances for MCO or PIHP programs.

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 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 submitted its quality strategy to the CMS Regional Office with the managed care plans’ contracts for CMS approval on October 24, 2014. The State’s quality strategy is found in Section B.

_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):

Health Services Advisory Group (HSAG) is the State’s contracted External Review Organization (EQRO). The current contract term is July 1, 2013 through June 30, 2018. For mandatory activities, the EQRO evaluates one clinical and one non-clinical performance improvement plan annually for the following six contracted LTC plans. The optional EQRO activities include conducting an encounter data validation project and providing technical assistance to the plans.

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 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) (l)(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. Written 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.**
Part 4: 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 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.

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

1. ___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.

Section 409.9122(2)(d), F. S. 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. ___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):

   Spanish
   Creole

The State has chosen these languages because (check any that apply):
   a. The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
   b. ___The languages comprise all languages in the service area spoken by approximately 5 percent or more of the population.
   c. 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

_X_ 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):

- Spanish
- Creole

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

a. The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

b. _X_ The languages comprise all languages in the service area spoken by approximately _5_ percent or more of the population.

c. Other (please explain):

_X_ please describe. How oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

The approved LTC contract provides:

Translation Services and Availability of Translated Materials

a. The Managed Care Plan is required to provide oral translation services to any enrollee who speaks any non-English language regardless of whether the enrollee speaks a language that meets the threshold of a prevalent non-English language.

b. The Managed Care Plan is required to notify its enrollees of the availability of oral interpretation services and to inform them of how to access such services. Oral interpretation services are required for all Managed Care Plan information provided to enrollees, including notices of adverse action. There shall be no charge to the enrollee for translation services.

c. If the Managed Care Plan meets the five percent (5%) threshold for language translation, the Managed Care Plan shall place the following alternate language disclaimer on all enrollee materials:

“This information is available for free in other languages. Please contact our customer service number at [insert enrollee help line and TTY/TTD numbers and hours of operation].”

The Managed Care Plan shall include the alternate language disclaimer in both English and all non-English languages that meet the five percent (5%) threshold. The Managed Care Plan shall place the non-English disclaimer(s) below the English version and in the same font size as the English version.
The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program. Please describe.

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

a. Potential Enrollee Information. Information is distributed to potential enrollees by:

- State contractor (Automated Health Systems) An independent enrollment broker is 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)

b. Enrollee Information

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

- the State
- State contractor (please specify): Automated Health Systems
- 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 CPR 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 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 CPR 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. _X_ 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 conducted public information sessions, including outreach to tribal organizations, about this program in each of the State’s 11 geographic regions. The State contracted with an independent enrollment broker to handle outreach, informing and enrollment-related activities.

The State developed strategies to inform potential enrollees, providers, and others of the LTC Program. The outreach and education efforts helped to facilitate the transition of all affected individuals by ensuring they were informed of changes and potential impacts. The State assessed all outreach strategies to identify additional information that was needed to conduct an effective outreach for this program.

Outreach activities were targeted at providers, advocates, other agencies, current and potential Medicaid participants, and other stakeholders. To accomplish this, the State developed strategic partnerships with community providers, including the local Aging and Disability Resource Centers and other entities, to provide increased awareness of the LTC program in each geographic region. Education activities focused on informing current and potential Medicaid enrollees of the LTC program and the benefits of coordinating institutional and HCBS under one contracted managed care organization.

b. Administration of Enrollment Process.

____ State staff conducts the enrollment process.

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

__X__ 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:

_ X_ choice counseling
_ X_ 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.):

Describe the state's strategy to assist beneficiaries entering the long-term managed care LTC program with enrollment, choice counseling, and complaints.

The Agency provides choice counseling assistance to recipients who are in the enrollment process. The enrollment broker provides recipients information about the selected LTC plans in the recipient’s region. The enrollment broker can be reached via toll-free number or through a secure web-based application. Recipients may contact the Agency for clarification or assistance. Recipients retain the right to petition the State, for a Fair Hearing and may also engage the Agency’s on-line and telephone complaint system for any complaints with the LTC plan. The Agency also supports recipients’ choice to change managed care plans within the 60-day open enrollment period each year.

Mandatory and voluntary recipients receive welcome letters and plan information within two business days of the enrollment broker being notified of their eligibility for the LTC program. Recipients have 120 days to make an initial plan choice. For mandatory recipients, a second letter is sent to inform them of their auto assignment to a LTC plan. Mandatory recipients must contact the enrollment broker by the last day of the enrollment month to avoid being enrolled with the auto assigned plan. If the mandatory recipient contacts the enrollment broker within 120 days of enrollment, the choice of another plan is effective on the first day of the following month. Voluntary recipients may change plans at any time and are not subject to annual open enrollment periods. After 120 days of enrollment, mandatory recipients may change plans for good cause.

LTC plans are required to develop an enrollee information program that includes detailed information about the various important aspects of the enrollee’s care. Written information is provided in various forms of required communication (i.e.: enrollee welcome package). LTC plans are required to maintain a website where recipients 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 with the recipients as part of case management requirements. This provides recipients the opportunity to discuss questions or concerns with someone familiar with their needs. Lastly, plans must operate a customer service line to answer recipient questions and address their concerns. These requirements are monitored by the State via the document approval process, LTC plan reporting requirements, centralized Complaint system, and annual monitoring.

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

LTC plans are required to have policies and procedures to manage this scenario. The State reviewed all policies and procedures during the plan readiness review period. Satisfactory policies and procedures were a condition of approval to begin enrolling recipients. Furthermore, the State required plans to include language in residential provider contracts detailing the provider’s responsibility to conform to the expected settings requirements as detailed in the waiver application. Plans are required to monitor ALFs and ALFs under CAP for compliance with all requirements prior to recipients accessing waiver services.
LTC plans are required to notify their recipients if they reside in a non-compliant ALF. The plan follows its standard notification procedure of sending written notification to the recipient and their legal representatives coupled with personal contact via the case manager. The case manager meets with the resident, and others chosen by the resident, to inform them of their choices to transition to any other network ALF. The case manager may facilitate visits to the prospective residences, if desired by the recipient. Once the recipient has chosen a new residence, the case manager will facilitate the move.

If a recipient chooses to remain in a non-compliant ALF the recipient may be disenrolled from the waiver. Disenrolling a recipient as a result of their choice to remain in a non-compliant ALF is an extreme, last resort, measure and would only be considered after the LTC plan and the State are unable to resolve the issue to the resident's satisfaction.

For involuntary disenrollment from the LTC plan, the State requires the LTC plan to submit the case notes, care plan, disenrollment recommendation, and other pertinent documentation to the Agency. The Agency must approve the involuntary disenrollment. The Aging and Disabled Adult Resource Centers works with the affected recipient to assist in finding suitable services that are not funded by the LTC program.

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

Long-term Care plans are responsible for credentialing and re-credentialing network providers to ensure they meet the minimum Medicaid provider 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 identification number, Medicaid provider registration number, or submission of the Medicaid provider registration form.

Long-term Care 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. Plans submit network files weekly and the files are monitored against contract network requirements for compliance.

The State reviewed basic licensing information for the provider's that LTC plans submitted to demonstrate prima-facie network adequacy as part of the solicitation process. Plans awarded contracts were required to submit complete network...
information. Credentialing files were reviewed for completeness and accuracy by the State during the plan readiness process and during annual monitoring thereafter. The state 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.):

___ 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.

___ Potential enrollees will have 120 days to choose a plan.

___ 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.

All LTC waiver recipients are considered to have special health needs therefore all LTC plans, and their network providers, must be able to serve populations with special health needs. The auto assignment process is based on a round robin assignment process where all LTC plans in a given region have an equal chance to receive mandatory recipient assignments as mandatory recipients become eligible. The assignment process looks to the recipient’s current LTC providers and seeks to match the recipient to those providers.

___ 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.

___ 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 through the enrollment broker and approved by the State. When a Medicaid recipient contacts the state’s enrollment broker to request an exemption from enrollment, the enrollment broker alerts the Agency and refers the request to the Agency. The Agency works with the individual and the LTC plan to try and reach a mutually acceptable solution. If this cannot be achieved, and other
available LTC 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 LTC.

_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.

      Good cause reasons for mandatory enrollees to change their LTC plan choice outside the open enrollment period are specified in Rule 59G-8.600, F.A.C.

   II. _____ 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 region
- 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.

**X** The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or 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)(S)(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.

**X** 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.

   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.

   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.

   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.

ALL LTC enrollees are considered to be persons with special needs. LTC plans are required to serve enrollees with special needs.

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.

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 non-procurement 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:

a. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

b. A person with beneficial ownership of five percent or more of the MCO’s, PCCM’s, PIHP’s, or PAHP’s equity;

c. 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.

2. Assurances For MCO or PIHP programs

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.

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 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 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.
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<th>Monitoring Activity</th>
<th>Evaluation of Program Impact</th>
<th>Evaluation of Access</th>
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<td>PCP/Specialist Authorization</td>
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<td>Coordination/Authorization</td>
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<td>Coverage/Capacity</td>
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<td>Provider Selection</td>
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<td>Provider Selection Selection</td>
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<td></td>
<td>Quality of Care</td>
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<tr>
<td>Accreditation for Non-duplication</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Accreditation for Participation</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Consumer Self-Report data</td>
<td>X X X X X X X X X</td>
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<td></td>
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<tr>
<td>Data Analysis (non-claims)</td>
<td>X X X X X X</td>
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<tr>
<td>Enrollee Hotlines</td>
<td>X X X X X X</td>
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<tr>
<td>Focused Studies</td>
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<td>X</td>
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<tr>
<td>Geographic Mapping</td>
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<tr>
<td>Independent Assessment</td>
<td>X X</td>
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<tr>
<td>Measure any Disparities by Racial or ethnic Group</td>
<td>X X</td>
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<td>X X</td>
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<tr>
<td>Network</td>
<td>X</td>
<td></td>
<td>X X</td>
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<td>Adequacy Assurances by Plan</td>
<td></td>
<td>X</td>
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<td>Ombudsman</td>
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<tr>
<td>On-Site Review</td>
<td>X X X X X X X X X X X</td>
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<td>Performance Improvement Projects</td>
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<td>Performance Measures</td>
<td></td>
<td>X</td>
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<tr>
<td>Periodic Comparison of # of Providers</td>
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<td>X</td>
<td>X X</td>
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<td>Profile Utilization by Provider Caseload</td>
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<td>Provider Self-Report Data</td>
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<td>Test 24/7 PCP Availability</td>
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<td>Utilization Review</td>
<td></td>
<td>X</td>
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<tr>
<td>Other: Desk Reviews</td>
<td>X X X X X X X X X X</td>
<td></td>
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</tr>
</tbody>
</table>
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. _X_ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

   _X_ NCQA
   _X_ JCAHO
   ___ AAAHC
   _X_ Other (Please Describe) - Utilization Review Accreditation Commission/American Accreditation Healthcare Commission (URAC/AAHC)

Applicable Program: LTC plan
Personnel Responsible: Long-term Care plans
Detailed Description of Strategy/Yielded Information:
Each LTC 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 LTC 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 State developed LTC Plan Enrollee 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: State developed LTC Plan Enrollee Survey-LTC Plans are required to participate in an independent survey of member satisfaction, currently the State developed LTC Plan Enrollee Survey conducted by the LTC plan through a required independent survey vendor on an annual basis. The LTC 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 survey is conducted annually. The State reviews the results and if any deficiencies are identified, 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 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: LTC plans
Detailed Description of Strategy/Yielded Information: LTC plan marketing and pre-enrollment complaints. LTC plans are required to submit their Medicaid marketing materials to the State. The State reviews the marketing materials based upon established review protocols. The LTC plans are notified of the review findings. Utilizing a monthly submission/review cycle, the managed care plans are required to submit new or amended marketing materials to the State for review and approval.

Frequency of Use: Marketing and pre-enrollment complaints are reviewed annually and investigated as they are reported to the State.

d. X Data Analysis (non-claims)
  X Denials of referral requests
  
  X Disenrollment requests by enrollee
    X From plan
    X From PCP within plan
    
  X Grievances and appeals data
PCP termination rates and reasons

Other (please describe)

Applicable Program: LTC
Personnel Responsible: State staff / LTC plans
Detailed Description of Strategy/Yielded Information: LTC Grievance System Survey - The LTC 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 LTC 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 LTC 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 requires quarterly reporting of new and outstanding grievances.

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

e. _X_ Enrollee Hotlines operated by State
   Applicable Program: LTC
   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. _X_ Geographic mapping of provider network
   Applicable Program: LTC
   Personnel Responsible: State staff / LTC plans
   Detailed Description of Strategy/Yielded Information: Frequency of Use:

h. _X_ Independent Assessment of program impact, access, quality, and cost-effectiveness (Required for first two waiver periods) The independent assessment of the LTC Program includes information on the impact, quality, and cost effectiveness of the waiver
Applicable Program: LTC
Personnel Responsible: Contracted Independent Assessor
Detailed Description of Strategy/Yielded Information: Independent assessment of the
access includes a comparison of number and types of LTC providers participating in each
plan before and after the waiver.
Frequency of Use: Every 5 years for first two waiver periods.

i. Measurement of any disparities by racial or ethnic groups
Applicable Program: LTC
Personnel Responsible: Contracted Independent Assessor
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. Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]
Applicable Program: LTC
Personnel Responsible: State staff
Detailed Description of Strategy/Yielded Information: Availability/Accessibility of Services.
Long-term Care plans provide assurances that the plan, has sufficient capacity to serve the
expected enrollment in each service area. The plans are required to offer an appropriate
range of services and access for the populations expected to be enrolled and to maintain
sufficient number, mix, and geographic distribution of providers.
Frequency of Use: Provider directories are reviewed semi-annually yearly and when
necessary to determine minimum network standards.

k. Ombudsman:
Brief description of the Independent Consumer Support Program (ICSP): The
Independent Consumer Safety Program (ICSP) is a coordinated effort by the Florida
Department of Elder Affairs’ (DOEA)’s 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.

DOEA has more than 10 years of experience as the oversight entity between the State and
its long-term care Medicaid recipients, contracted health plan and aging network providers
to ensure the system is responsive to service issues and quality of care. DOEA builds 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.

I. – X On-site review
   I.1 Applicable Program: LTC
   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 LTC plans are reviewed and monitored using comprehensive survey tools to identify any non-compliant areas. If non-compliant areas are identified, corrective action is required within a given time frame. If the corrective action is not completed within the agreed upon time frames, the plan may be subject to sanctions or liquidated damages. The response to any corrective action and/or contract actions could be taken such as the imposition of sanctions or liquidated damages. If the non-compliance is not corrected in the given time frame, or if the corrective action is not completed within the agreed upon time frames, the plan may be subject to sanctions or liquidated damages.

   The State conducts annual on-site reviews of the LTC 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

### I.2 Applicable Program: LTC

**Personnel Responsible:** State staff

**Detailed Description of Strategy/Yielded Information:** LTC plan Disenrollment

Summary: State staff performs reviews of recipient disenrollment files to assess the accuracy of these reports and to review the documentation of reasons for disenrollment. These reviews include a review of disenrollment due to patient deaths and disenrollment for reasons reported as other.

**Frequency of Use:** Annually

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### m. _X_Performance Improvement projects [Required for MCO/PIHP]

- _X_Clinical
- _X_Non-clinical

**Applicable Program:** LTC

**Personnel Responsible:** State staff / LTC plans

**Detailed Description of Strategy/Yielded Information:** Quality of care studies -

Long-term Care plans must perform at least two (one clinical and one non-clinical), Agency-approved, quality of care studies that comply 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 LTC contract. If plans are out of compliance, then corrective action may be required and/or other contract actions will be taken such as imposition of sanctions or liquidated damages.

**Frequency of Use:** Quarterly over each contract period.

### n. _X_Performance measures [Required for MCO/PIHP]

- Process
- Health status/outcomes
n.1 Applicable Program: LTC
Personnel Responsible: State staff
Detailed Description of Strategy/Yielded Information: Long-term Care plan quality and performance measure reviews are performed at least annually, at dates 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 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
Personnel Responsible: State staff / LTC plans
Detailed Description of Strategy/Yielded Information: LTC plan staff licensure. The LTC 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 monitors each plan at least annually and reviews 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
Personnel Responsible: State staff / LTC plans
Description of Strategy/Yielded Information: Quality Improvement - The LTC 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
Personnel Responsible: State staff / LTC plans
Detailed Description of Strategy/Yielded Information: Independent Member Satisfaction Survey - Long-term Care plans participate in enhanced managed care quality improvement through an independent survey of member satisfaction. The current survey was developed by the State and conducted by the LTC plans through a contract with an independent survey vendor.
Frequency of Use: Annually
n.5 Applicable Program: LTC
Personnel Responsible: State staff / LTC plans
Detailed Description of Strategy/Yielded Information: Availability/Accessibility of Services- See response to "j" above.
Frequency of Use: Provider directories are reviewed by the State semi-annually or more frequently when necessary.

o. Periodic comparison of number and types of Medicaid providers before and after waiver:
Each contracted LTC plan's network of providers are assessed for adequacy and readiness. All LTC plans are required to submit a report of their provider network, to ensure that numbers and types of providers are adequate. If the State determines that provider networks are not adequate, the State looks for specific trends that might impact access to services.

p. Profile utilization by provider caseload (looking for outliers)
The State performs 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 bearing requests. Service utilization patterns before and after program implementation will be closely monitored to ensure that medically necessary services continue to be provided.

q. Provider Self-report data
   _X_Survey of providers
   ___Focus groups
   ___Review of provider feedback

q.1 Applicable Program: LTC
Personnel Responsible: State staff / LTC plans
Detailed Description of Strategy/Yielded Information: LTC plans are required to submit new or amended marketing materials to the State for review and approval monthly.
Frequency of Use: Monthly and On-going

q.2 Applicable Program: LTC
Personnel Responsible: State staff / LTC Plans
Detailed Description of Strategy/Yielded Information: The Agency reviews the marketing event requests using State review protocols. Prior to conducting approved events, the LTC plans are notified of the review findings. Each subsequent event request is reviewed by the Agency to ensure contract provisions are met regarding all marketing, public, and educational events.

Frequency of Use: Monthly.

q.3 Applicable Program: LTC
Personnel Responsible: State staff / LTC plans
Detailed Description of Strategy/Yielded Information: The Agency uses two methods to verify the LTC plans use of approved marketing representatives: A) each LTC plan’s Marketing, Public, and Educational Event Report is reviewed monthly to verify approved marketing events and representatives by comparison with the Department of Financial Services list of licensed and or registered marketing representatives; B) Marketing Status Agent reports are reviewed quarterly to verify approved marketing representatives are scheduled for approved events.

**Frequency of Use:** Monthly or quarterly and as needed.

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

s. **Utilization review** (e.g. ER non-authorized specialist requests LTC plans are required to submit periodic service utilization reports to be monitored by desk review. The State monitors whether LTC 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.

**Frequency of Use:** As needed

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**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.

_X_ 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.

_X_ 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 of the activities identified in Section B:

**Strategy:**

**Conducted as described:**

___ Yes

___ No (Please Describe)

**Summary of Results:**

**Problems Identified:**
Corrective action (Plan/provider level):

Program change (system-wide level):

**b. Strategy:** Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

**Conducted as described:**

_✓_ Yes

___ No (Please Describe)

**Summary of Results:** All six plans participating in the LTC program submitted their accreditation within eighteen months of being awarded the contract. Humana purchased American Eldercare and began to operate the combined plans in July 2015.

**Problems Identified:** No problems identified.

**Corrective action (Plan/provider level):** None.

**Program change (system-wide level):** None.

c. **Strategy:** Consumer Self-Report data

c.1 **Strategy:** LTC plans are required to use State developed LTC Plan Enrollee Survey to annually survey their plan members. See copy of the LTC Plan Enrollee Survey for details of enrollee questions in Attachment C.

**Conducted as described:**

_✓_ Yes

___ No (Please Describe)

**Summary of Results:**

Long-term Care Plan Enrollee Survey Results Summary
Survey during Calendar Year 2015

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>LTC Plan Rating - % rating plan an 8, 9, or 10</th>
<th>Contacting Case Manager - % responding Usually or Always Easy</th>
<th>Case Manager Rating - % rating on 8, 9, or 10</th>
<th>LTC Services - % responding Usually or Always on time</th>
<th>LTC Services Rating - % rating services an 8, 9, or 10</th>
<th>Overall Health - Improved since enrolled in LTC Plan</th>
<th>Quality of Life - Improved since enrolled in LTC Plan</th>
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<tbody>
<tr>
<td>Statewide</td>
<td>80%</td>
<td>83%</td>
<td>84%</td>
<td>90%</td>
<td>83%</td>
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<td>American Elder Care</td>
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<td>88%</td>
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<td>59%</td>
<td>79%</td>
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<tr>
<td>Sunshine</td>
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<td>78%</td>
<td>88%</td>
<td>79%</td>
<td>53%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Problems Identified: The statewide rate detailed in the chart on the top line listed six items with rates less than 85%.

Corrective action: (Plan/provider level): The State is in the process of determining a corrective action plan for the reported items with rates less than 85%.

Program change: (system-wide level): None

c.2 Strategy: Marketing and pre-enrollment complaints

Conducted as described:

___Yes

_X_No (Please Describe)

During SMMC Plan readiness, marketing review activities took place in the months of March and April of 2014. LTC plans were required to submit their marketing materials for the Agency's review. The State reviewed the submitted marketing materials based upon established review protocols. The LTC plans were notified of the review findings. Utilizing a monthly submission/review cycle, the managed care plans are required to submit new or amended marketing materials to the State for review and approval.

Summary of Results: LTC plan's monthly submissions are reviewed by the State and requests for compliance actions are referred to Agency management for review and approval. The approved request for compliance action can range from additional plan technical assistance up to liquated damages.

Problems Identified: None.

Corrective action (Plan/provider level): None.

Program change (system-wide level): None

d. Strategy: Data Analysis (non-claims)

Conducted as described:

___Yes

_X_No (Please Describe)

Summary of Results: The Agency has a 24/7 Complaint Reporting process, to quickly identify, resolve and track LTC plan complaints, to ensure a seamless transition of services for elderly and disabled Medicaid recipients. Recipients can call a toll-free number to speak to an Agency employee during business hours or submit a complaint using has a web-based 24/7 Complaint Form as the entry point for all complaints. For any urgent issues, the State makes contact with the recipient the same day, and intervenes with the LTC Plan to initiate a resolution.

Summary of Results: See Attachment D for Summary of Complaints.

Problems Identified: See Attachment D for complaint details

Corrective action (Plan/provider level): Changes made as necessary to address complaints.

Program change (system-wide level): None.
e. Strategy: Enrollee Hotline Operated by the State

Conducted as described:
___Yes
__X__No (Please Describe)

The State operates the Medicaid Help Line. Medicaid representatives, including certified choice counselors, are available by phone at 1-877-254-1055; Telecommunications device for the deaf (TDD) at 1-866-467-4970. Medicaid Help Line staff can accommodate all languages. The Medicaid Help Line ceases accepting new calls each day at 5:00 p.m. ET. However, since Florida spans two time zones, a unit of Medicaid Help Line staff has been stationed in the Central Time Zone, in the Pensacola Office. This Unit continues to work with callers until 6:00 p.m. ET. Individuals with a complaint or issue related to the Long-term Care Program are also able to submit an online complaint form 24/7, at http://apps.ahca.myflorida.com/smmc_cirts/. The Agency has also established Youtube, Facebook and Twitter pages, which promote the availability of both the Medicaid Help Line and the online complaint form.

Summary of Results: See Attachment D for Summary of Complaints.

Problems Identified: Identified problems addressed individually as necessary.

Corrective action (Plan/provider level): None.
Program change (system-wide level): None.

f. N/A

Strategy: Focused Study

Conducted as described:
___Yes
___No (Please Describe)

Summary of Results:

Problems Identified:

Corrective action (Plan/provider level):

Program change (system-wide level):

q. Strategy: Geographic mapping of provider network

Conducted as described:
___Yes
__X__No (Please Describe)

The LTC contract requires provider networks to have at least two service providers for each covered service in each county in the plan’s service area. The contract does not require provider networks to have distance and time metrics for provider network adequacy. LTC plans submit their provider network lists quarterly for verification of compliance with the contract requirements through the Provider Network Verification
System (PNV).

**Summary of Results:** The quarterly submissions have been verified. No plans were found to be out of compliance with contract requirements.

**Problems Identified:** None.

**Corrective action (Plan/provider level):** None.

**Program change (system-wide level):** None.

**h. Strategy:** Independent assessment of program impact, access, quality, and cost-effectiveness

**Conducted as described:**

```
_X_ Yes
_   _ No (Please Describe)
```

**Summary of Results:** The key findings indicate there has been a modest increase in quality of care under the LTC program for most indicators across the three sites of care: 1) Home (those receiving home and community-based services (HCBS) and living in private homes); 2) other residential settings (ORS); and 3) nursing facilities (NF). The findings also suggest that enrollees are satisfied with their services, have contact with case managers, and are receiving appropriate services. Almost 75% of respondents to the LTC enrollee satisfaction survey felt their quality of life had improved since enrolling in their LTC plan.

**Problems Identified:** None. However, the independent assessment made the following recommendations: 1) Perform comprehensive annual assessments for all enrollees using the 701B comprehensive assessment Instrument; 2) Require that plans submit all findings from annual assessments to the Agency 3) Review the protocol and training for conducting the 701B comprehensive assessment, specifically as related to measures of depression; 4) Continue to evaluate the indicators of quality that have been identified in this report; and 5) Continue to review and analyze data in greater detail.

**Corrective action (Plan/provider level):** None.

**Program change (system-wide level):** None.

**i. Strategy:** Measurement of any disparities by racial or ethnic groups

**Conducted as described:**

```
__Yes
_X_ No (Please Describe)
```

The independent assessment covered the three-month period of statewide operations that occurred during its review period. This period was too limited to make meaningful measurement of any disparities by racial or ethnic groups. The independent assessment provided a list of participating racial groups in Florida’s LTC program from 2012-2014 on page 20 of the independent assessment located in Attachment B. The next independent assessment will examine the program again for racial disparities after four years of operation.

**Summary of Results:** None.
Problems Identified: None.
Corrective action (Plan/provider level): None.
Program change (system-wide level): None.

i. Strategy: Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]

Conducted as described:
___Yes
_X_No (Please Describe)

The LTC plans are required to submit their provider directory policies and procedures, along with a printed copy of their provider directory and information regarding web-accessible directories for review. The LTC’s printed provider directory was compared to the plan’s online directory to ensure consistency between published information and on-line directory information. The State reviewed the provider directories utilizing established review protocols to ensure compliance with contract provisions. LTC plans update the printed provider directory at least every six months and ensure the provider directory (either printed or online) matches the most recent provider network file submitted to the Agency.

Summary of Results: All LTC plan provider networks were determined to meet contract standards for adequacy. The State found the plan’s provider directories and policies as well as their on-line provider directories to be compliant with the contract requirements.

Problems Identified: None.
Corrective action (Plan/provider level): None.
Program change (system-wide level): None

k. Strategy: Ombudsman

Conducted as described:
_X__Yes
___No (Please Describe)

Summary of Results:

<table>
<thead>
<tr>
<th>Type of Complaint/Issue</th>
<th>Total Number of Complaints/Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuum of Care/Missed Services</td>
<td></td>
</tr>
<tr>
<td>Coverage Limitation</td>
<td>1</td>
</tr>
<tr>
<td>Customer Service</td>
<td>71</td>
</tr>
<tr>
<td>Desired Provider not in Network</td>
<td>2</td>
</tr>
<tr>
<td>Eligibility</td>
<td>32</td>
</tr>
<tr>
<td>Enrollment/Plan Change</td>
<td>15</td>
</tr>
<tr>
<td>Grievance/Appeal</td>
<td>37</td>
</tr>
<tr>
<td>Notice of Case Action</td>
<td>15</td>
</tr>
</tbody>
</table>
Problems Identified: The reported issues were referred to Agency complaint hub for resolution.

Corrective action (Plan/provider level): The issues were resolved on an individual basis and did not represent a general trend requiring program changes.

Program change (system-wide level): None

I. Strategy: On-site review

I.1 Strategy: On-Site Reviews

Conducted as described:

_X_ Yes
___No (Please Describe)

Summary of Results:

The annual on-site and desk reviews were completed by DOEA and results were forwarded to the Agency. The Agency requested revised and updated forms and care plans as necessary. Plans corrected their deficiencies revealed in the on-site and desk reviews.

Problems Identified: Although some plan's forms and careplans were incomplete, the Agency received the corrected information in follow-up submissions. The follow-up form submissions resolved the forms compliance issues.

Corrective action (Plan/provider level): None

Program change (system-wide level): None.

I.2 Strategy: Disenrollment Summary

Conducted as described:

___Yes
_X_ No (Please Describe)

The State's desk reviews examined each LTC plan's disenrollment files to verify accuracy. LTC plans may not voluntarily disenroll plan members. The Agency reviews and approves plan member disenrollment requests for voluntary disenrollment. Plans may request involuntary disenrollment of plan members for
the following reasons: plan member moving out of the region; loss of Medicaid eligibility; enrollee death; and determination that an enrollee is an excluded population under the contract.

**Summary of Results:**
Plans’ disenrollment files were found to comply with contract requirements.

**Problems Identified:** None.

**Corrective action (Plan/provider level):** None.

**Program change (system-wide level):** None

**m. Strategy:** Performance Improvement Projects

**Conducted as described:**

___ Yes

_X_ No (Please Describe)

The State contracted with an EQRO to review the LTC plans’ performance improvement projects. The plans’ performance improvement submissions are due each July 1 for review and validation.

**Summary of Results:** For the first two submissions the EQRO reviewed the plans’ basic design of their performance improvement plan using the CMS approved template. Basic design issues included invalid research questions and data collection problems.

**Problems Identified:** Plans with non-met items on their templates were given an opportunity to correct the template or design issues.

**Corrective action (Plan/provider level):** Plans were required to revise their research questions and refines their data collection procedures.

**Program change (system-wide level):** None.

**n. Strategy:** Performance Measures

**n.1 Strategy:** Quality and Performance Measure reviews

**Conducted as described:**

___ Yes

_X_ No (Please Describe)

The State conducts annual reviews of the Agency defined performance measures. The performance measures are calendar year based and have been reviewed annually for compliance with the LTC program contract.

**Summary of Results:** The initial performance measures exceeded the contract standards for care plan development and initial LTC plan member contacts. The performance measures were amended to reflect the actual contract standards for these requirements.

**Problems Identified:** Initial performance measures for initial member contact
and care plan development exceeded the contract requirements.

Corrective action (Plan/provider level): This issue resolved itself after the initial roll-out of the program and the actual contract requirements were used in the performance measures.

Program change (system-wide level): Program contract was amended.

n.2 Strategy: Staff licensure reviews

Conducted as described:

___Yes

_X_No (Please Describe)

The State established the PNV System to verify the LTC plan’s licensed provider network on a quarterly basis. The LTC plans submit the provider networks quarterly to the State for verification and compliance with the contract.

For plan licensed staff, the desk review process verifies the plan’s licensed staff on an annual basis.

Summary of Results: Plan provider networks were found to be in compliance with the program contract. Plan licensed staff were determined to be licensed as required by the contract.

Problems Identified: None.

Corrective action (Plan/provider level): None.

Program change (system-wide level): None.

n.3 Strategy: Quality Improvement

Conducted as described:

___Yes

_X_No (Please Describe)

See item m of this section for description.

Summary of Results: Plans with non-met items on their templates were given an opportunity to correct the template or design issues.

Problems Identified: The first two submissions reviewed the plans’ basic design of their performance improvement plan using the CMS approved template.

Corrective action (Plan/provider level): None.

Program change (system-wide level): None.

n.4 Strategy: Independent Member Satisfaction Survey

Conducted as described:

___Yes

_X_No (Please Describe)
Since no long-term care version of the CAHPS was available the State developed the LTC Plan Enrollee Survey and required the LTC plans to contract with an independent survey vendor to conduct the survey on an annual basis.

**Summary of Results:** See item c1 for chart displaying survey results.

**Problems Identified:** The statewide rate detailed in the chart on the top line listed six items with rates less than 85%.

**Corrective action (Plan/provider level):** The State is in the process of determining corrective action requirements for these items.

**Program change (system-wide level):** None.

**o. Strategy:** Periodic comparison of number and types of Medicaid providers before and after waiver implementation.

Conducted as described:

___ Yes

_X__ No (Please Describe)

Quarterly desk reviews of PNV system reviews provide a basis for comparison of service providers before and after implementation of the LTC Waiver.

**Summary of Results:** LTC plans have been able to attract more service providers for waiver services to their provider networks than contract network adequacy requirements.

**Problems Identified:** None.

**Corrective action (Plan/provider level):** None.

**Program change (system-wide level):** None.

**p. Strategy:** Profile utilization by provider caseload (looking for outliers)

Conducted as described:

_X__ Yes

___ No (Please Describe)

**Summary of Results:** Desk reviews examined profile utilization difference by plan caseload. Differences in service utilization were based upon plan member preference for services in their home versus other service locations such as an adult day care center.

**Problems Identified:** None.

**Corrective action (Plan/provider level):** None.

**Program change (system-wide level):** None.

**q. Strategy:** Provider Self-report Data
q.1 Strategy: Marketing and Pre-enrollment Materials

Conducted as described:

____Yes

_ X__No (Please Describe)

item C.2 of initial waiver document for description.

Summary of Results: See item c.2 for summary of

Problems Identified: See item c.2 for problems identified.

Corrective action (Plan/provider level): None.

Program change (system-wide level): None.

q.2 Strategy: Health Fairs and Public Events

Conducted as described:

___Yes

_ X__No (Please Describe)

The first Marketing, Public, Educational Event Report was received from the LTC plans on June 20, 2014 to reflect events to take place during the month of July 2014. The State reviewed the event requests using Agency-established review protocols. The LTC plans were notified of the review findings and then were able to begin to attend approved events. On a monthly basis, each plan submits a Marketing, Public, and Educational Event Report to reflect event attendance for the following month. Each report is reviewed by the State to ensure contract provisions are met.

Summary of Results:

The State reviews found no compliance issues with plan event reports and use of approved marketing representatives.

Problems Identified: None.

Corrective action (Plan/provider level): None.

Program change (system-wide level): None.

q.3 Strategy: Marketing Representatives

Conducted as described:

___Yes

_ X__No (Please Describe)

The State uses two methods to verify the plan use of approved Marketing Representatives: 1) each LTC plan’s Marketing, Public, and Educational Event Report is reviewed monthly to verify approved marketing events and representatives by comparison with the Department of Financial Services list of licensed and or registered marketing representatives and; 2) the Marketing Status Agent Report is reviewed quarterly to verify approved marketing representatives are scheduled by plans for approved events.

Summary of Results:
The State reviews found no compliance issues with plan event reports and use of approved marketing representatives.

Problems Identified: None.
Corrective action (Plan/provider level): None
Program change (system-wide level): None

r. **N/A**
Strategy: Test 24 hours/7 days a week PCP availability
Conducted as described:
___ Yes
___ No (Please Describe)
Summary of Results:
Problems Identified:
Corrective action (Plan/provider level):
Program change (system-wide level):

s. **Strategy**: Utilization Review
Conducted as described:
___ Yes
___ No (Please Describe)
Quarterly desk reviews are used by the State to review service utilization of LTC Plans. Plans submit sampled care plans to the Agency for review. Service utilization outliers are reviewed and followed up with the plans.

Summary of Results:
Plans have provided explanations for service utilizations that appeared to be excessive in some cases.
Problems Identified: None.
Corrective action (Plan/provider level): None.
Program change (system-wide level): None.

t. **Strategy**: Desk Review
Conducted as described:
___ Yes
___ No (Please Describe)
Summary of Results: See item S for an example of the State’s use of desk reviews to examine a program issue.
Problems Identified: None.
Corrective action (Plan/provider level): None.
Program change (system-wide level): None.
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. 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 RO 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. Dan McClary

d. Telephone Number: 850-412-4798

e. E-mail: Dan.McClary@ahca.myflorida.com

d. The State is choosing to report waiver expenditures based on ___ date of payment.

X ___ 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. X PIHP
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:
d. [Required] Explain any other variance in eligible member months from BY to P3:

   e. [Required] List the year(s) being used by the State as a base year: ___. 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 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:

   Member month increase were based on actual growth trends.

   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: SFY13/14 and SFY 14/15.

F. Appendix D2.S - Services in Actual Waiver Cost
For Initial Waivers:
   a. [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.

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: *Same services*

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

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 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. 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.

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.

<table>
<thead>
<tr>
<th>1915(b)(3) Service</th>
<th>Savings projected in State Plan Services</th>
<th>Inflation projected</th>
<th>Amount projected to be spent in Prospective Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>Total</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1915(b)(3) Service</th>
<th>Amount Spent in Retrospective Period</th>
<th>Inflation projected</th>
<th>Amount projected to be spent in Prospective Period</th>
</tr>
</thead>
<tbody>
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</table>

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. 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. X The State provides stop/loss protection (please describe):
The LTC program includes a budget-neutral Community High Risk Pool (CHRP) risk mitigation mechanism for the HCBS rate cell. A percentage of HCBS rates is withheld to fund the CHRP. Seventy-five percent of member expenditures greater than $7,500 per month (“pooled claims”) are eligible to be reimbursed by the CHRP. At the end of the contract period, if CHRP funds are inadequate to reimburse
all pooled claims, the pooled claims will be funded on a proportional basis for each MCO. If CHRP funds exceed the level of pooled claims, excess CHRP funds will be returned to MCOs on a PMPM basis.

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*). Please document how that trend was calculated:

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

b. ____ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for
changes that occur after the BY (or after the collection of the BY data) and/or during P1, 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. ___ 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**: 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).
      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. ___ 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. ___ 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):

**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. ___ 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.

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

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. ___ 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. ___ 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._X__[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. __X__ State historical cost increases. Please indicate the years on which the rates are based: base years __SFY 2013-2015___. 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 actual expenditure data were the primary source for determining trend for the prospective period. 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, P2 to P3, P3 to P4, and P4 to P5 was assumed at the projected average of 7% based upon the historical averages.

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._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 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).

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. _____ 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. X 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 membership projections assume enrollment growth at approximately 1.1% per quarter.**

    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:

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, P2 to P3, P3 to P4 and P4 to P5 was assumed at the projected average of 7% based upon the historical averages and fluctuations experienced by this population.

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.
Attachment A
Independent Consumer Safety Program
Attachment C
Long-term Care Plan Enrollee Survey
Attachment D
Complaint Summary
Attachment E
Tribal Notification
Ms. Cassandra Osceola  
Health Director  
 Miccosukee Tribe of Florida  
P.O. Box 440021, Tamiami Station  
Miami, FL 33144  

Dear Ms. Osceola:  

The Agency for Health Care Administration (Agency) is amending our previous notification letter to you regarding our request to renew the Long-term Care (LTC) waiver for a five year period.  This letter alerts you to two additional changes that will be made in the waiver renewal request submitted to the Centers for Medicare and Medicaid Services. The additional changes are the last two bullets below (bold of emphasis). The following is a description of the waiver, the changes being requested, and information on how to provide comments and suggestions.  

The Long-term Care Waiver Request  
The purpose of the Long-term Care waiver is to provide a choice of long-term care home and community-based services for eligible disabled and elderly adults in Florida as an alternative to nursing facility services for their long-term care needs.  

The State has made the following changes in the renewal application which differ from the original approved waiver:  

- revise the case management provider qualifications;  
- revise the performance measures;  
- update the spousal impoverishment policy;  
- update the waiver’s personal needs allowance description;  
- update the requirements related to physical therapy;  
- update the waiver’s unduplicated enrollee count and related waiver cost projections;  
- remove the structured family caregiving service; and  
- update the waiver specific home and community-based transition plan.  

The waiver amendment request document can be viewed at:  

If you have any comments or questions about this waiver renewal, please contact Keith Young of my staff via email at Keith.Young@AHCA.myflorida.com or by phone at (850) 412-4257.  

Sincerely,  

Justin M. Senior  
Deputy Secretary for Medicaid  

JMS/ky
April 27, 2016

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

Dear Ms. Whidden:

The Agency for Health Care Administration (Agency) is amending our previous notification letter to you regarding our request to renew the Long-term Care (LTC) waiver for a five year period. This letter alerts you to two additional changes that will be made in the waiver renewal request submitted to the Centers for Medicare and Medicaid Services. The additional changes are the last two bullets on the list below (bolded for emphasis). The following is a description of the waiver, the changes being requested, and information on how to provide comments and suggestions.

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- update the spousal impoverishment policy;
- update the waiver’s personal needs allowance description;
- update the requirements related to physical therapy;
- update the waiver’s unduplicated enrollee count and related waiver cost projections;
- **remove the structured family caregiving service; and**
- update the waiver specific home and community-based transition plan.


If you have any comments or questions about this waiver renewal, please contact Keith Young of my staff via email at Keith.Young@AHCA.myflorida.com or by phone at (850) 412-4257.

Sincerely,

Justin M. Senior
Deputy Secretary for Medicaid

JMS/ky
Attachment F
Summary of Changes