Sent: Wednesday, October 30, 2013 6:14 PM
To: FLMedicaidWaivers
Subject: Comments regarding the 1115 MMA Waiver Extension Request

Dear Sir or Madam,
Please accept the attached comments on behalf of the Florida Renal Coalition.
Thank you.

(See attached file: FRC MMA Public Comments 103013.doc)

Bob Loeper

Florida Renal Coalition

4953 Van Dyke Road
Lutz, FL 33558
Telephone: (813) 961.1217 X211 ■ Fax: (813) 968.0406

October 30, 2013

1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Comments submitted via e-mail: FLMedicaidWaivers@ahca.myflorida.com

RE: Extension of Florida's Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4)

The Florida Renal Coalition (FRC) continuously strives to improve the overall delivery and access to care for renal dialysis to all Floridians. We offer the following comments to the extension of the Florida Managed Medical Assistance (MMA) waiver specific to the needs of people with kidney failure receiving life-sustaining dialysis treatments.

Prior Authorization: We are pleased to hear in the public meetings that AHCA has a goal of decreasing the administrative burden related to prior authorizations and that part of the evaluation of MMA contractors is the ability to process prior authorizations electronically. We would like to know if there is a prior-authorization required for someone on dialysis. Since kidney failure is life-long unless they receive a kidney transplant, we are hoping there is not a requirement that is too burdensome (such as monthly or quarterly prior-authorizations). At most, we believe an initial prior authorization would suffice.

Dialysis Treatment Co-pay. Assessing a copay per MD office visit is a current and acceptable practice with managed care organizations. However, with dialysis patients requiring three treatments per week, we feel copays per treatment are a financial burden to a vulnerable population for life maintenance procedures. We request that the MMA program prohibit the plans from assessing copayments on a per dialysis treatment basis.

Transportation Co-Pay: While the transportation co-pay is reasonably priced at $1.00 per trip, dialysis patients have, at a minimum, 26 trips per month to and from dialysis treatments. This does not include additional trips to physician offices or other medical services related to their many co-morbid conditions. While $26 may not seem like a costly amount for transportation, it can be difficult for people on very low, fixed incomes. We are concerned that if dialysis patients are unable to pay their co-pay it will result in their skipping dialysis treatments, which would result in costly hospitalizations. We request that the co-pay be waived for outpatient treatments that are not optional, such as dialysis.

Network Adequacy: While nephrologists are listed on the Provider Network Standards list (Table 8), we request that out-patient dialysis facilities also be listed. Because individuals must dialyze at a minimum of three times a week, a robust network of dialysis facilities is important to provide access to dialysis care. We suggest a maximum distance of 30 miles or

Florida Renal Coalition

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30 minutes in Urban Counties and a maximum distance of 50 miles/50 minutes in Rural Counties.

Dental Co-Pay: The costs of dental care can mean the difference between staying on dialysis or qualifying for a kidney transplant. It is not unusual for people to get stuck in the transplant evaluation process because they are unable to afford the required dental care. The proposed co-insurance for adult dental is 5% per procedure. We are requesting it be changed to 5% co-insurance per procedure with a maximum of $10 per procedure.

Thank you for considering these comments. We appreciate the information that has been shared at the public meetings and in the proposal document. Please contact me for any further information or questions.

Sincerely,

Robert P. Loeper
Executive Director
Florida Renal Coalition

Sent: Wednesday, October 30, 2013 6:03 PM
To: FLMedicaidWaivers
Subject:

Please find attached our comments conderning 1115 Waiver.
Thank you.

Evie Fox

Justin Senior
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Dear Mr. Senior,

This letter is in response to the invitation to comment on the proposed roll out of the Managed Medical Assistance (MMA) program as described in the 1115 Waiver posted on the AHCA Website. The Florida Association of Healthy Start Coalitions is recommending that the MMA implementation include access to Mom Care services for all women enrolled in SOBRA Medicaid. The Agency has indicated its intention to limit access to the Mom Care program to only a few encounters for women who are enrolled in the Presumptive Eligibility for Pregnant Women (Medicaid Category MU). Under the current proposal, the women who are enrolled in SOBRA Medicaid though the Simplified Eligibility for Pregnant Women (MMP) will not receive any MomCare services. The magnitude of the proposed reduction potentially jeopardizes this decentralized, statewide delivery system.

According to the waiver request "a primary goal of the waiver is to improve the Medicaid delivery system which would in turn improve health outcomes for Medicaid recipients in the State of Florida." In addition, the waiver request states " Quality will continue to be a primary focus of the MMA program. As noted above, the Agency has used performance measures to identify areas in need of improvement throughout the Florida Medicaid program. These performance measures include HEDIS® measures,…... Because the Medicaid program in Florida has an outsized role in the birth process (paying for more than half of all deliveries), and **due to the room for improvement in this area**, **prenatal/postpartum care …..will be a primary area in which the state will focus improvement efforts by its plans"**.

The average performance by managed care organizations on HEDIS measures cited in the waiver support the observation that improvements are needed. Four reform managed care plans and 12 non-reform plans were sanctioned based on their 2012 prenatal/ post partum performance measures. These performance measures, early enrollment in prenatal care, compliance with ongoing visits and participation in post-partum care are the specific behaviors that MomCare services are designed to influence.

The Special Terms and Conditions (STC) include the following description of the MomCare Program **"**outreach and case management services for **all women presumptively eligible and eligible for Medicaid under SOBRA**. The MomCare component is mandatory for these women as long as they are eligible for Medicaid, and offers initial outreach to facilitate enrollment with a qualified prenatal care provider for early and continuous health care, Healthy Start prenatal risk screening and WIC services. Recipients may disenroll at any time. In addition, the MomCare component assists and facilitates the provision of any additional identified needs of the Medicaid recipient, including referral to community resources, family planning services, Medicaid coverage for the infant and the need to select a primary care physician for the infant."

This language describes the program as a comprehensive set of services that are to be offered to all SOBRA eligible women. It does not indicate, or seem to imply, any reservations about

overlapping services provided by MomCare and the MCOs. The language and placement in the STC seem to suggest it is part of the new MMA environment.

Women who are enrolled in SOBRA Medicaid are newly enrolled in Medicaid and, currently are called by a MomCare Advisor shortly after becoming eligible for services. Data from FY 2012-13 show that 58% of women were contacted within 5 days of the referral, 89% of women voluntarily chose their provider and, over 99% were enrolled with the provider within 30 days. This short turnaround time for enrollment is essential if performance measures for first trimester entry are to improve.

A comparison of SOBRA eligible women to other Medicaid pregnant women, done by the University of Florida under contract with the Agency, shows that the women enrolled in SOBRA had a higher incidence of first trimester enrollment, less “inadequate care”, and better birth outcomes.

It is important to note that SOBRA women are the largest group of Medicaid pregnant women and were not required to enroll in managed care during the pilot program. Restricting access to services that have been shown to have a beneficial effect on this population may have negative statewide consequences.

At the current payment of $6.50 per month the MomCare services are estimated to cost about $52 of federal funds per woman for the entire eligibility period. This includes approximately 2 months of post partum services during which MomCare Advisors help women who will no longer be eligible for Medicaid enroll their infants in pediatric care, access family planning services and, in 2014, explore possible new resources for primary care. The amount needed to support ongoing services is a very modest investment for purchasing a proven delivery system. Maintaining access to MomCare system of services will result in outcomes that the state Medicaid Program has identified as a priority.

The Florida Association of Healthy Start Coalitions is advocating for a policy that protects the progress we have made in facilitating improved access to prenatal care. It will also enhance the ability of Managed Care Organizations to build on a stable service delivery system to promote further improvements.

We recommend that the Mom Care services be provided to all SOBRA women throughout pregnancy at the current fee structure. Experience suggests it is essential to maintain the outreach component for all SOBRA eligible women to ensure early and continuous enrollment in prenatal care and a post partum experience that supports infant and interconceptional health.

Sincerely,

Evie Fox
President Florida Association of Healthy Start Coalitions.

Sent: Wednesday, October 30, 2013 5:02 PM
To: FLMedicaidWaivers
Subject:

Amanda Heystek • Managing Attorney

DISABILITY RIGHTS FLORIDA

COMMENTS TO MMA WAIVER EXTENSION REQUEST

Disability Rights Florida thanks the Agency for Health Care Administration for pursuing public input in its request to renew the 1115 Waiver for Managed Medical Assistance. The documents provided on AHCA's website were helpful and informative. However, the majority of the language was aspirational and difficult to comment on without concrete measures being employed in the selected Health Plans. As of today, we learned Molina Healthcare of Florida will be awarded a contract in three different regions pursuant to a bid protest settlement. As such, Disability Rights Florida, offers these comments as constructive guideposts and suggestions to ensure continuity of quality care for persons with disabilities. We look forward to providing additional comments as opportunities arise.

CMS' Amendment approval for Florida's 1115 Waiver for Managed Medical Assistance in June 2013 included twenty one Special Terms and Conditions along with retention of improvements added to the demonstration plan such as enhanced managed care requirements, a Medical Loss Ratio of 85% and the continuation of the Low Income Pool. Additionally, the approval was conditioned upon new stakeholder engagement process and consumer protections to ensure beneficiary education, assistance and continuity of care. The amendment approval also required the development of a comprehensive quality strategy that reflects the health needs of Florida beneficiaries across the state's Medicaid program at large, that has specific data-driven achievable goals and strategies, and that is aligned with the broader goals of improving care and lowering cost through care improvements. These comments shall attempt to speak directly to the information provided in AHCA's Public Notice Document Waiver Extension Request Released October 1, 2013, and align with CMS' conditions for the approval of the amendment.

Consumer protections

The penalties and sanctions for plans that reduce enrollment levels or leave a region before the end of the contract term have increased, but the language shared in AHCA's public notice only requires "departing provider serves networks" to continue services for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. There is no statement of what a beneficiary would experience if there are no other plans available for enrollment within 90 days following termination.

A comprehensive network of specialty physicians and their sustainable rates is imperative to persons with disabilities. Disability Rights Florida recognizes AHCA is requiring "the plans must maintain a panel of preventive and specialty care providers sufficient in number, mix and geographic distribution to meet the needs of the enrolled population." Once plans are finalized and enrollment is complete, this requirement should be ascertainable and measured by AHCA or its EQRO. It is commendable that AHCA

has made increased access to specialists a part of its second objective. However, better reporting of this issue should be completed by requiring the plans to separately measure referrals to specialists. We would like to further recommend that MCA care providers be prompted to participate in disability awareness training. The questions asked in the CAHPS Survey for the demonstration and pilot programs were indicative of the ease of getting an appointment after the referral to the specialist was made, but, those CAHPS Survey questions may not have adequately captured the ease of getting a referral and prior authorization to see a specialist in the first place. Additionally, in furtherance of AHCA's objective to increase access to specialty care, it is suggested that AHCA continue the three current types of specialty care (orthopedics, neurology, and dermatology) in its tracking of encounter data and add additional specialties over time.

Disability Rights Florida supports ongoing communication networks with people with disabilities, including expanded outreach and advisory groups. The Medicaid medical Care Advisory Committee should assure that at least two of the representatives of Medicaid recipients were either self-advocates or family members of persons with disabilities to ensure this population is adequately represented.

Comprehensive Quality Strategy

A description and intended means for measurement of the "data-driven achievable goals and strategies" for Florida's plans was not found in the public notice document. Disability Rights Florida looks forward to reviewing AHCA's goals and strategies for measurement and requests additional information.

The Quality Initiatives listed on page 22 seek to hold the plans accountable for on-going quality in such areas as: coverage and authorization of services; clinical outcome measures; enrollee satisfaction, provider access and timeliness of care; network adequacy, etc. However, there are only seven areas listed as required reporting components and they do not directly relate to the beneficiary's satisfaction of the program. Measuring grievances and appeals is one way to measure satisfaction but it does not capture those beneficiaries who were dissatisfied but did not have the time or energy to follow through with a grievance or appeal.

The data of requests for Medicaid fair hearings shows an increase in the trend from 30 requests in Year Four to 93 in Year Seven. It is commendable that many were resolved. However, since Year Four, approximately 30-37% of fair hearings requested proceeded all the way through hearing. It is not stated if the four hearings that were decided in favor of the plan were in one given year or spread out among the seven years tracked, but such a low number may indicate that plans are not authorizing services or alleviating grievances at the plan level as they should be doing. For 95% of beneficiaries (those that received adverse actions, sought an appeal and won) the time and energy spent navigating the appeal process is lost and unrecoverable. The AHCA could require reporting of the subject matter of Medicaid Fair Hearings, justifications used to deny prior authorizations, and the outcomes to better identify best practices or standards for the approval of beneficiary's requests and to ensure that the plan's processes are not disproportionately affecting particular groups such as persons with disabilities.

AHCA's public notice document states that the agency's contract with the EQRO has not included a specific HEDIS® validation deliverable since the March 2012 report but does not explain why, or when another HEDIS® validation deliverable could be required.

The CAHPS survey measured "how often was it easy to get care, tests or treatment" but did so with only two answers – usually and always. What it did not measure was when it was not easy to get care, tests or treatment. Of the four years charted in Chart O, roughly 69% of those surveyed answered with one of the two charted positive answers. Therefore, it must be presumed that roughly 30% of the beneficiaries felt it was not easy to get care, tests or treatment their doctors felt necessary. One third of the beneficiaries could otherwise be said to feel their health care needs are not being met which seems to be a high rate of dissatisfaction that should be addressed. A separate patient advocate system for people with disabilities that responds quickly to patients who have complaints/grievances would be beneficial and alleviate the time and energy a person with a disability would have to expend in navigating the grievance or appeal process. Lengthy waits seriously affect the health of people with disabilities and chronic illnesses who need access to timely and appropriate care.

Again, thank you for the opportunity to provide these comments.

Sincerely,

/s/

Amanda Heystek, Esquire
Managing Attorney
Disability Rights Florida

And

/s/
Kara Hinkley, MPP
Manager, Southeast Advocacy
National Multiple Sclerosis Society

Sent: Wednesday, October 30, 2013 4:59 PM
To: FLMedicaidWaivers
Subject: Comments from Florida Legal Services

Please find attached comments from Florida Legal Services on the 1115 MMA Waiver Extension Request.

Thank you.

--

Anne Swerlick

FLORIDA LEGAL SERVICES, INC.
2425 TORREYA DRIVE TALLAHASSEE, FL 32303 - PHONE: 850.385.7900 - FAX: 850.385.9998

A. HAMILTON COOKE
PRESIDENT

KENT R. SPUHLER
DIRECTOR

VIA U.S. MAIL & EMAIL

October 30, 2013

1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308
FLMedicaidWaivers@ahca.myflorida.com

RE: 1115 MMA Waiver Extension Request

Dear Deputy Secretary Senior:

On behalf of Florida Legal Services, Inc., (FLS) we are submitting these comments supplemental to those we have filed concerning behavioral health care services for children. These comments are directed to the additional waiver issues detailed below.

Low Income Pool

AHCA is seeking to increase its request for LIP funding from $1 billion per year to $3 billion. The Public Notice Document states:

> "…reauthorization of the LIP funding at increased levels is a critical source of funding for care to the Medicaid, underinsured and uninsured populations. A reduction or static level of funding would undoubtedly result in reduction and access to care for the Medicaid, uninsured and underinsured populations." p. 46

It is undisputed that this funding deficit is in large part attributable to Florida's rejection of Medicaid expansion dollars. While the Public Notice Document does not specify the number of uninsured individuals served by LIP who would be eligible for Medicaid under expansion, we assume it is a sizeable chunk. The Kaiser Family Foundation recently released a study estimating that 763,890 Floridians are in the "coverage gap"- those individuals who cannot purchase insurance on the federal exchange, but who also do not qualify for Medicaid under its current very low income eligibility criteria. *See The Coverage Gap: Uninsured Poor Adults in State That Do Not Expand Medicaid*, The Kaiser Commission on Medicaid and the Uninsured, Issue Brief October 2013, available at: http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

While we certainly support Florida's safety net providers getting adequate funding to meet the unmet medical needs of the uninsured, undoubtedly if Florida pursued Medicaid expansion, it would greatly obviate the need for LIP funding. LIP dollars will never be an adequate substitute for the individualized comprehensive preventive and acute care coverage attached to Medicaid eligibility and coverage. It makes little public policy or fiscal sense for Florida to reject federal Medicaid expansion dollars and simultaneously ask for increased federal LIP dollars. (*See* enclosed 10/17/13 Tampa Bay Times article). Federal and state Medicaid dollars will go much further than LIP dollars to ensure access and quality care for low income Floridians.

If Florida continues to get LIP dollars we urge the Agency to develop protocols for LIP providers to coordinate with enrollment activities under the Affordable Care Act. For example, every uninsured person served by LIP dollars should be informed of and assisted with enrollment in health care coverage available through the ACA marketplace or Florida's current Medicaid program. Notably, AHCA's recently issued legislative budget request for 2014-2015 proposes limiting the medically needy program to persons below 100% of the poverty level. The rationale for this proposed reduction is that individuals at or above 100% of the poverty level will be able to purchase insurance on the Marketplace. While we oppose this Medicaid reduction proposal, if it goes forward, the need for coordinated enrollment activities by LIP providers to ensure that these individuals are in fact able to obtain coverage through the Marketplace will be all the more important.

Further, every hospital LIP provider should have protocols in place to perform presumptive Medicaid eligibility under the new Affordable Care Act provisions. The state has not yet adopted any rules implementing these new ACA provisions. Since this new law goes into effect January 1, 2014, we urge AHCA, in conjunction with its sister agency, the Department of Children and Families, to promptly initiate the rule-making process.

Cost-sharing

The Public Notice Document lists co-payment/co-insurance amounts currently permissible under Florida's state plan and states that plan cost-sharing must be consistent with the state plan. *See* p. 14. However, some of the state plan cost-sharing amounts do not comply with new federal cost-sharing limitations included at 42 CFR § 447.52-.53. (e.g., pharmacy and dental services coinsurance requirements). These cost-sharing amounts must be changed to conform to the new federal law.

Medical Loss Ratio Requirement

While we very much appreciate the inclusion of a medical loss ratio (MLR) requirement in the Terms and Conditions of the current (2011-2014) Waiver Extension, we are puzzled and concerned that the Agency's Waiver Extension Request apparently makes no mention of the MLR. As described below and in previous correspondence, an enforceable Medicaid MLR

requirement in Florida's Medicaid managed care program is absolutely critical.[1] At a minimum the MLR requirement should be discussed in the extension request's sections relating to "Accountability and Monitoring" and "Penalties and Sanctions" (Sections G and H), and it should specify that for all accounting purposes, the requirements set forth in 45 C.F.R. Part 158 will apply.

Florida's Current Title XIX and XXI MLR Requirements

Advocates have long been urging that the legislature require at least an 80-85% MLR requirement of Medicaid HMOs *and* their subcontractors. If more than 15 to 20 % of the Medicaid capitated payments go to administrative and profit related expenses, there will be insufficient funding to cover necessary direct health care services.

Florida has long had an 85/15 MLR requirement for the state's Title XXI Program, Florida Healthy Kids (FHK) plans, and an 80/20 MLR for Medicaid behavioral services. In 2012 the Legislature passed Fla. Stat. 409.967(4) allowing the Agency to calculate MLR if required as a condition of a waiver. The state has developed expertise in administering MLR provisions and has successfully recovered millions of dollars from plans that failed to meet these reasonable MLR requirements. FHK plans have been required to refund over $22 million. Similarly, since 2006 Medicaid plans have been required to refund the state $24 million for their failure to meet the MLR behavioral health requirements. This does not include millions of dollars related to the 2010 Wellcare whistleblower complaint discussed below.

Critical Role of MLR in Controlling Fraud and Abuse

The 2010 Wellcare whistleblower complaint underscores the need for an enforceable MLR requirement. The grievous allegations in the complaint would not have come to light without the whistleblower and the MLR requirement. As FLS mentioned at the October 9, 2013 public meeting in Miami, given that we obviously cannot rely on "whistleblowers," it is all the more critical that meaningful and enforceable MLR standards are in place.

Achieved Savings Rebate (ASR) and MLR Differences

The state's Achieved Savings Rebate (ASR), which is mentioned in the Extension Request, does not provide the same consumer protections as the MLR. The MLR is designed to ensure that a certain percentage of plan total revenue goes into actual health care costs as opposed to administrative costs and profit. By contrast, the ASR provisions solely address the issue of health plan profits and fails to target excessive administrative costs and insufficient spending on

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[1] We could not find any reference to MLR after reviewing relevant sections in hard copy and doing electronic word search. However, even if MLR is mentioned in the extension request, it lacks necessary explanation regarding how the state plans to implement and enforce this critical consumer protection. The Agency also apparently failed to include reference to the MLR requirement in the "Florida Managed Medical Assistance Program: *Program Overview*".

patient care. Further, the ASR provisions give tremendous discretion to the agency and the actuaries to determine "allowable administrative costs", and these arcane and technical determinations will likely occur without adequate public access or oversight.

Moreover, under the ASR, the state gets to keep plan profits over a certain percentage. In other words, the state Medicaid Agency will essentially "be in business" with private companies. The more profit the plans make, the more revenue the state will make. This has the potential to create perverse financial incentives for the state. While advocates certainly support controlling excessive plan profits and increasing state revenue, the limited state resources devoted to plan monitoring should be focused on ensuring adequate care for vulnerable Medicaid recipients.

Thus, enforcing MLR standards more appropriately aligns the interests of state monitors (including the state's financial interest in collecting fines from noncompliant plans) with those of consumers. In terms of ensuring that most of the public Medicaid money goes to pay for patient health care services and improvement, rather than to plan administration, the MLR is a far superior mechanism.

MLR Requirements are also Critical for Health Plan Subcontractors

The HMOs that contract with AHCA often execute subcontracts with third party vendors to provide specific covered services. We also raised concerns with the Agency at the October 9, 2013 public meeting regarding subcontractors being subject to MLR requirements and public records requirements.

Pursuant to the state's "Health Plan Model Contract, the plan under contract with AHCA must provide data related to its MLR in response to a public records requests. Thus, the Agency and the public can determine how much public money the plan receives and how much of that public money the plan pays its network providers for their enrollees' health care services. For subcontractors, however, there is still a need to address transparency and accountability.

The following example illustrates this issue. Therapy Review Systems (TRS) contracted with Amerigroup (AG), a Medicaid HMO, to provide covered therapies (including speech therapy) to Medicaid eligible children enrolled in Amerigroup. In 2009, FLS was contacted by several of TRS' network speech therapists who alleged that TRS was improperly denying coverage for medically necessary therapy. FLS filed public records requests with TRS related to their medical loss ratio, i.e. how much money TRS received each month from AG as a capitated payment for each enrollee, and how much of this public money TRS then expended on therapy services for the Medicaid enrollees. TRS refused to answer, claiming that it was not subject to the state's public records law and that, even if it was, the records related to MLR are exempt from disclosure as a "trade secret." On behalf of Florida Community Health Action Information Network ("CHAIN"), a public records lawsuit was filed in Miami-Dade County Circuit Court against TRS during August 2010.[2]

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[2] While the public records lawsuit was pending, AHCA conducted a review of speech therapy denials and fined Amerigroup $ 2,655,000 for allegedly denying medically necessary therapy

In June, 2011, the court found that TRS was subject to the public records law, but they could not be compelled to disclose records related to its MLR because that information is a "trade secret." *See* Order, Attachment E. Thus, pursuant to this court order, the Florida public is prevented from knowing how much public money a Medicaid plan subcontractor receives and how much of that money is actually spent on the enrollee's specific health care services. This case highlights the ongoing need for an MLR requirement which applies to all Medicaid plans as well as their subcontractors. In this regard, it is again critical that the federal regulations apply. For example, the provisions at 45 C.F.R. ¶158.140 (b) (3) (ii) help ensure that the overall MLR requirement is not undermined through subcontracting with third party vendors.

We appreciate the Agency's consideration of these comments. Please don't hesitate to contact us if you have questions or need additional information.

Sincerely,

Anne Swerlick
Miriam Harmatz

---

services to hundreds of Medicaid-eligible children. The AHCA letter noted that Agency staff had met with staff from the Plan and TRS regarding Agency concerns prior to imposition of the fine.

Tampa Bay Times

After saying no to feds on Medicaid expansion, Florida may ask for more money

Tia Mitchell, Times/Herald Tallahassee Bureau

Thursday, October 17, 2013 5:44pm

TALLAHASSEE — Months after Florida lawmakers rejected $51 billion from the federal government to expand Medicaid, state officials are prepared to request billions in new federal aid for a different program to improve care for the poor, uninsured and underinsured.

State officials want to grow Florida's Low Income Pool (LIP) program from $1 billion a year to possibly $3 billion a year, said Justin Senior, deputy secretary for Medicaid at the Agency for Health Care Administration. The additional money could help hospitals cover charity care, provide premium support for low-income Floridians or expand health care programs.

"Our feeling at the agency is that there are opportunities here to make the LIP program larger," Senior told lawmakers, who didn't object. "We have talked with the federal government about that, and the federal government, by and large, they seem generally receptive to the possibility of it."

Even contemplating accepting additional federal LIP dollars seems at odds with the Legislature's stone-cold rejection of additional Medicaid funding tied to health care reform. But it highlights how intertwined Tallahassee and Washington are — whether Republican lawmakers in the state Capitol like it or not.

Rep. Matt Hudson, a Naples Republican and chairman of the House's health care budget committee, said it's best to keep the two discussions separate.

"While opponents would love to water down the House's opposition to Medicaid expansion to a single sound bite, it's not that simple," he said in an email. "We will evaluate these decisions based on the long term physical and fiscal well-being of Florida."

For years, the Legislature has signed off on leveraging local tax dollars to qualify for additional health care funding from the federal government. But it's hardly enough, health care officials say, and less than what states like Texas and California receive.

"Florida is embarrassingly low in the amount of money it gets from the federal government in supplemental payments," Tony Carvalho, president of the Safety Net Hospital Alliance of Florida, told the panel.

Florida receives roughly $1.4 billion a year in supplemental Medicaid funding, according to a report commissioned by Carvalho's organization. California collects about $5 billion a year for similar programs and Texas expects $7.5 billion each year, the same study said.

Texas uses the money to help pay hospitals that treat large numbers of uninsured patients and to fund innovative health programs.

Florida officials say the state will tie the request for more funding to Florida's application for an extension of the federal waiver that privatized Medicaid. The waiver application will be submitted in about a month. Most likely, the federal government will insist on new quality improvement benchmarks as a trade-off for any new money.

Linda Quick, president of the South Florida Hospital and Healthcare Association, said the need for more funding became even more pronounced after House Republicans blocked a plan to expand Medicaid to 1 million low-income Floridians earlier this year. The federal health care law also reduces some supplemental funding hospitals now receive.

Even if that weren't true, Florida will always have people who are uninsured or don't have enough insurance coverage, Quick said. And that means hospitals and health centers will always need this supplemental money, she said.

"Unfortunately, those people are not going anywhere, and they're not getting insurance," she said. "And therefore we need to continue to put money into the Low Income Pool."

The state is hoping the federal government will give at least conditional approval to its Medicaid waiver renewal and funding increase by early 2014. That will allow the Legislature time to pass any laws needed to implement it for the 2014-15 fiscal year.

House Republicans rejected Medicaid expansion largely because it relied on federal funding to reduce the number of uninsured. Now, they may be needed to sign off on how any new dollars are allocated.

"I suppose there is some sense of irony if not hypocrisy there," Quick said, "that we'll take money with a different title and tag on it."

Contact Tia Mitchell at tmitchell@tampabay.com.

After saying no to feds on Medicaid expansion, Florida may ask for more money 10/17/13

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State FLORIDA

a. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	
Prescribed Drug Services		X		Effective June 1, 2004, coinsurance will apply to prescribed drug services for recipients 21 years of age and older, who are not in a long term care facility and are not pregnant or receiving Family Planning Services or supplies; are not receiving Emergency Room services or supplies; or are not receiving Hospice services or supplies. Coinsurance amounts are as follows: 2.5% of the Medicaid payment up to $300, 0% of the Medicaid payment in excess of $300 per prescription, and 0% of Medicaid payments after total monthly beneficiary co-payments and coinsurance billed reaches 5% of total monthly family income. Providers are responsible for collecting the coinsurance from recipients and may not deny an initial service because of an individual's inability to pay coinsurance. An individual's inability to pay is based on his or her statement to the provider that they are unable to pay the required cost sharing. Inability to pay does not extinguish the liability of the individual to pay cost sharing. Authority for the maximum charge is 42 CFR 447.54(a)(2).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: FLORIDA

a. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge			Amount and Basis for Determinations
	Deduct.	Coins.	Copay	
Hospital Services: Non-emergency services in the hospital emergency room.		X		Effective July 1, 2003, there is a five (5) percent coinsurance charge to recipients 21 years of age or older on Medicaid payments greater than $0.00 through the first $300 per date of service for non-emergency services rendered in a hospital emergency room. There is 0% coinsurance on Medicaid payments in excess of $300. Providers are responsible for collecting the cost sharing charges from recipients not otherwise exempt. Providers cannot deny services to recipients who are unable to meet their cost sharing obligation. Authority for the maximum charge is 42 CFR 447.54(a)(2). All exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.
Dental Services: Complete dentures, removable partial dentures and all services related to the provision of complete and partial dentures.		X		There is a five (5) percent coinsurance charge to recipients twenty-one years of age or older who are not institutionalized, receiving hospice care or enrolled in an HMO. The 5 percent coinsurance applies to the amount of Medicaid payment made for the services and not the provider's charges for services. Providers are prohibited from denying services to recipients who are unable to meet their cost sharing obligation. Basis for determination was the maximum charge offered at 42 CFR 447.54(a)(2). The exemptions to cost sharing noted in 42 CFR 447.53(b)(1)-(5) apply.

Sent: Wednesday, October 30, 2013 4:37 PM
To: FLMedicaidWaivers
Subject: Comments on 1115 MMA Waiver Extension Request

Please see attached. Thank you.

Greg Mellowe

Submitted on behalf of:
Florida CHAIN
Florida Center for Fiscal and Economic Policy

TO: Justin Senior, Deputy Secretary for Medicaid, Agency for Health Care Administration
FROM: Florida CHAIN and the Florida Center for Fiscal and Economic Policy
DATE: October 30, 2013
RE: Comments - Proposed Section 1115 Medicaid Waiver Extension Request

In response to the Public Notice Document posted on the Agency's Statewide Medicaid Managed Care webpage, the organizations listed above offer the following brief comments on Florida's proposed request to federal CMS for an extension of Florida's "Managed Medical Assistance" Medicaid 1115 Research and Demonstration Waiver.

As you know, the approval process for an 1115 waiver pertaining to an initiative as complex as the Managed Medical Assistance (MMA) program is unavoidably lengthy and involved, particularly given the fact that the Agency and CMS are creating new rules for the Medicaid program. Consequently, the Agency will submit this Waiver Extension Request to CMS only a few months after finalizing the Special Terms and Conditions (STCs) for the current 1115 MMA Waiver, which itself is an amendment to and replacement of the original 1115 "Medicaid Reform" Waiver.

In short, we recognize that the Agency, as a response to the Special Terms and Conditions negotiated with federal CMS for the 1115 MMA Waiver as well as for the 2011 extension of the original 1115 Medicaid Reform Waiver, has undertaken considerable efforts to improve quality, accountability and transparency in Florida's Medicaid managed care system (at least with regard to the acute care component.) Although 1115 waiver authority was not a prerequisite for the preponderance of the Agency's efforts in this regard, the improvements were undoubtedly most urgently needed in the original five-county Medicaid Reform Pilot area.

However, all of the main elements of the MMA program have yet to be implemented outside of the original five Pilot counties. Accordingly, given the historical problems with the Medicaid Reform experiment, we remain concerned, despite the improvements and required precautions, about the potential for chaos and confusion that may accompany the roll-out of the MMA programs, and the potentially adverse impact on patients in terms of access to and quality of care. We intend to urge CMS not to grant the Agency any additional waiver authority or discretion until the roll-out of MMA as described under the current 1115 MMA waiver has been completed and thoroughly evaluated. As we have argued persistently, the potential risk to vulnerable patients associated with doing too much too quickly cannot be justified.

Furthermore, despite the addition of what will hopefully be access-enhancing improvements (e.g., specialty area-specific network adequacy standards), we remain concerned that the Agency continues to selectively define and present concepts, metrics and other key information in a manner that paints an inappropriately rosy picture of the situation under the current 1115 MMA

Waiver. We reiterate our ongoing objection to the Agency's reliance on raw and/or over-aggregated utilization rates without context as a basis for purportedly demonstrating that care is not being inappropriately delayed or denied. Many of the steps the Agency indicates that it is taking or will take in this area simply repeat assurances that have been made but never fulfilled over many years.

Furthermore, we are unclear as to the nature of the additional Waiver authority the Agency is seeking with respect to cost-sharing. Page 96 of the Public Notice Document refers to the need for waiver authority to allow "cost sharing for all Medicaid eligibility categories participating in the waiver." We would strongly object to any proposed increase in cost-sharing obligations above currently approved levels for currently permitted eligibility categories.

We urge you to take additional measures – measures that are appropriately within AHCA's purview as the State Medicaid Agency - to convey to the Governor and Legislature that the expansion of Medicaid to include most adults under 138 percent of the federal poverty level is essential for the sustainability of Florida Medicaid as well as in the best interests of Florida. Particularly in light of the fact that the Agency considers access to additional Low Income Pool dollars to be a crucial short-term strategy toward that end, it is imperative that the Governor and Legislature understand that expanding Medicaid would be even more effective, with impacts enduring over a much longer period of time. As you know, the vast majority of the newly eligible under Medicaid expansion would be enrolled in managed care plans.

Finally, we urge you to build in additional opportunities to receive and meaningfully use input from all stakeholders. Again, the Agency has improved in the area of public participation opportunities. However, seeking the perspective of consumers and their advocates in particular continues to be an afterthought in comparison with the breadth and depth of efforts made to reach and accommodate what we perceive to be the Agency's "primary stakeholders. Consumers and their advocates still lack the opportunity for dialogue with the Agency as well as a medium by which they may ask meaningful questions for which the Agency does not already have a pre-determined and potentially recipient-averse answer.

Thank you for your consideration of these important issues.

Sent: Wednesday, October 30, 2013 12:28 PM
To: FLMedicaidWaivers
Subject: 1115 MMA Waiver Extension Request

1. Although the 1115 Managed Medical Assistance waiver is not linked to the Patient Protection and Affordable Care Act, can the 1115 MMA waiver be amended to include an additional (expanded Medicaid) group of able bodied adults earning up to 133% federal poverty level?

2. If so, have the selected managed care organizations been queried regarding their capacity to serve an expanded Medicaid population?

3. Are leaders in the Florida Senate and House of Representatives aware of the capacity or lack thereof to expand Medicaid using the 1115 MMA waiver managed care organizations?

Allan March, MD

Sent: Wednesday, October 30, 2013 11:42 AM
To: FLMedicaidWaivers
Subject: 1115 MMA Waiver Extension Request

Please find attached Florida Legal Services, Inc.'s comments on the 1115 Waiver Extension Request. A hard copy was also sent by U.S. Mail.
Thank you,

Amy K. Guinan

FLORIDA LEGAL SERVICES, INC.
2425 TORREYA DRIVE TALLAHASSEE, FL 32303 - PHONE: 850.385.7900 - FAX: 850.385.9998

A. HAMILTON COOKE
PRESIDENT

KENT R. SPUHLER
DIRECTOR

October 30, 2013

VIA US MAIL & EMAIL

1115 Waiver Extension Request
Deputy Secretary Justin Senior
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr., Mail Stop #8
Tallahassee, FL 32308
FLMedicaidWaivers@ahca.myflorida.com

RE: 1115 MMA Waiver Extension Request

Dear Deputy Secretary Senior:

Thank you for your presentation on Florida's 1115 Managed Medicaid Assistance (MMA) Waiver at the recent Medical Care Advisory Committee (MCAC) meeting on October 15, 2014. We appreciate the time you took to discuss in detail the progress of Florida's new statewide managed care delivery system and the Waiver Extension Request, as well as your willingness to answer numerous questions and encourage input from consumers, providers and other interested parties.

We are pleased about the increased consumer protections in the MMA program you noted in your presentation, including increased recipient participation on the MCAC and immediate review of recipient complaints, grievance and appeals through the rapid cycle response system. We are also hopeful about the possibilities the Child Welfare Specialty Plan may provide in improving health care access to this population. We do, however, have several questions and concerns relating to how behavioral health services will be provided under the requested Waiver Extension and new MMA program to children in, and exiting, the child welfare system. We ask you to consider and address these issues as you move forward with the Waiver Extension Request and the implementation of the MMA program.

The lack of clarity with regard to behavioral health services for youth up to age 21 has been a longstanding issue of concern for us, other advocates, and providers seeking to serve this population. As you know, federal Medicaid EPSDT law requires that behavioral health services limited to children and youth be available for Medicaid-eligible youth up to age 21. There has been confusion, however, with regard to certain behavioral health services provided to children in foster care that has led some providers and state agency representatives to mistakenly conclude that these of types of behavioral health services are no longer covered once the youth turns 18.

For example, in our practice we continue to encounter youth over, or within months of turning, 18 who have difficulty accessing inpatient psychiatric services because providers and case workers believe such Medicaid covered services are limited to SIPP services for youth under 18. While we understand that participation in the current SIPP waiver program is limited to those under 18 as a result of the terms of the current SIPP waiver, similar inpatient psychiatric hospital services must be available for youth up to the age of 21. Questions also exist for Specialized Therapeutic Services and Behavioral Health Overlay Services coverage. For instance, the most recent available draft of the proposed Specialized Therapeutic Services Coverage and Limitations Handbook noticed by the Agency in June 2013 included language inappropriately limiting specialized therapeutic foster care and therapeutic group care services to recipients under the age of 18. We understand that these services are provided through foster care and currently children age out of foster at the age of 18, but similar services still must be available for youth up to the age of 21.

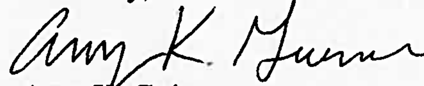
Recent legislation extending age limits for foster care has increased the need and urgency for the Agency to provide clear direction and clarification regarding coverage for behavioral health services for youth age 18 to 21. SB 1036, which was passed by the Legislature during the 2013 Session and signed by the Governor on June 24, 2013, provides foster children the option to stay in foster care until age 21. These new provisions extending foster care will go into effect very soon – on January 1, 2014 – several months before the Agency expects to begin the staggered regional implementation of the MMA program. Yet there are still many unanswered questions, as well as incorrect and potentially dangerous assumptions being made by stakeholders throughout the child welfare community as to what will happen to the current SIPP Waiver and how Medicaid will be provided under the new managed care delivery system to youth who choose to remain in foster care until 21. Clarity on the behavioral health issues discussed above cannot wait until implementation of the MMA program begins in the spring of 2014. In order to ensure youth who choose to remain in foster care receive the behavioral health services they require, we ask that the Agency make it a priority to provide clear direction – prior to the January 1st effective date – on how these behavioral health services are to be provided to this population both under the MMA program and in the time remaining until staggered regional implementation begins. We also ask that you make it a priority to ensure that the applicable provider handbooks are upd ted to comply with the requirements of the Foster Care Extension law.

Finally, in addition to updating the current behavioral health handbooks, we ask that as you move forward with implementation of the Waiver Extension and the MMA program, you place priority on drafting a new rule and handbook relating to inpatient psychiatric services. In representing children in need of current SIPP services, we have found that the lack of a SIPP Coverage and Services Handbook has often contributed to confusion and inconsistencies in the implementation of policies and procedures among the regional circuits throughout the state. While several documents exist that give insight into current SIPP policies and procedures (including the SIPP 1915(b) Waiver Application document, the subsequent renewal applications, the 2004 SIPP Request for Proposal and subsequent contracts, and the Magellan document entitled "Medicaid Utilization Management Statewide Inpatient Psychiatric Programs Florida Agency for Health Care Administration"), they have not always been consistent or easily accessible, nor do they adequately take the place of a promulgated rule and handbook. Furthe ıore, these documents will no longer provide any relevant guidance under the MMA program once health plans become responsible for providing SIPP-type services and the current SIPP waiver expires. Therefore, to ensure a smooth transition from the current SIPP waiver to the MMA program, it is critical that a properly promulgated rule and handbook for inpatient

psychiatric services be published prior to starting the staggered regional implementation in the spring of 2014.

We appreciate this opportunity to provide input to the Agency on the Waiver Extension Request and implementation of the MMA program. We look forward to continuing discussions with you as you continue to implement the MMA program. Please let us know if we can be of assistance.

Sincerely,



Amy K. Guinan

Anne L. Swerlick
Deputy Director of Advocacy

Sent: Tuesday, October 29, 2013 1:18 PM
To: FLMedicaidWaivers
Subject: 1115 MMA Waiver Extension Request

To Whom it May Concern:

Attached please find comments from the Florida Dental Association regarding the 1115 MMA Waiver extension request. If you have any questions, please feel free to contact me at the information below.

Thanks,
Casey

HEADQUARTERS
1111 E. Tennessee St.
Tallahassee, FL 32308-6914
Phone: (800) 877-9922 • (850) 681-3629
Fax: (850) 561-0504
E-mail: fda@floridadental.org

GOVERNMENTAL AFFAIRS OFFICE
118 E. Jefferson St.
Tallahassee, FL 32301
Phone: (850) 224-1089
Fax: (850) 224-7058
E-mail: gao@floridadental.org

FLORIDA DENTAL ASSOCIATION

FOUNDED 1884

October 29, 2013

1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

To Whom It May Concern:

The 1115 Managed Medical Assistance (MMA) waiver requires that all Medicaid sponsored health care services including dental care be integrated under managed care organizations (MCOs) by October 2014. The Florida Dental Association (FDA) supports the independence of Florida's dental managed care program and the pending legislation before the Florida Legislature to exclude dental care from the scope of services of the MMA.

The Florida Medicaid Reform Demonstration (Reform Pilot) began in 2006 and currently serves approximately 250,000 children in Broward, Duval, Clay, Baker and Nassau counties. Under the Reform Pilot, medical managed care organizations sub-contracted with two prepaid dental health plans (plans), MCNA and DentaQuest, to administer dental benefits to their members. The Reform Pilot was the model adopted by the 2011 Legislature for the MMA. However, since January 2012, the State has contracted directly with the same two plans, to provide dental benefits to all Medicaid eligible children in each county, except the five Reform Counties. The Legislature's goal was to continue to transition the Medicaid dental program to managed care by building upon the success of the pre-paid dental health pilot program (PDHP) in Miami-Dade County. Even though the PDHP has been more successful in improving access to dental care rates than the Reform Pilot, the PDHP will expire on October 1, 2014 and be replaced by the integrated health care model of the 2011 MMA legislation.

The FDA's main concern with the MMA is the unnecessary layers of administrative costs that will ultimately impact the amount of funds that go to providers who deliver dental care to children in the managed care program. Currently in the Reform Pilot, all but one MCO sub-contracts dental services from independent dental plans such as MCNA and DentaQuest. Additionally, the MCOs that have submitted bids for the MMA program have subcontracted for dental services from independent dental plans. Based on the experience in the Reform Pilot, these sub-contracting arrangements will include an additional layer of administrative costs well in excess of 10% that will be levied by MCOs. This additional layer of administrative costs does not exist under the current PDHP contracts with AHCA and it will further dilute the funds available to provide dental care to Florida's children. The current system, independent dental managed care, works to ensure the limited Medicaid funds available for dental care are focused on patient care, specifically prevention and treatment, and not administrative costs. If the MMA integrated care model, which adds an additional unnecessary layer of administrative costs to the dental program, is adopted it will further deplete the already grossly underfunded Medicaid dental program. It is the FDA's position that Florida does not invest enough in dental care for the Medicaid enrolled population. Of the $22 billion appropriated by the Florida Legislature for Medicaid services, less than 1% (approx. $200 million) is allocated to the dental program.

Furthermore, the Prepaid Dental Health Plans are currently required to incur an 85:15 spend ratio ensuring accountability for taxpayer dollars for dental care and outreach for members, rather than administration. There is no provision in the MMA requiring the 85:15 spend ratio on dental by the health plans. Based on the experience in the Reform Pilot counties, the MMA's will most likely maintain the spending ratio at the health plan level while dental plans will receive less dollars to provide care. This disconnect will trickle down to dental providers in the form of lower fee schedules and reduced access to care. Thus, the FDA believes that under the MMA, a health plan will invest considerably less resources in its dental program as experienced in the Reform Pilot.

The Agency for Health Care Administration (AHCA) has suggested embedding pediatric dental services into Medicaid health plans will permit coverage for adults as well as children. But the problem is that the state doesn't intend to pay any more for dental care than the pittance it does now. Does AHCA expect health plans to spread the already miniscule dollars that used to be meant for children to also pay for care provided to adults? The effort to promote adult dental care by somehow combining it with children's dental may be well-intended but will only exacerbate problems in the future. If adult dental is something that the state wants to offer, nobody is stopping the Legislature and Medicaid from paying health plans more to do so. But robbing Baby Peter to pay Adult Paul isn't the way to get there.

The following Florida programs maintain dental benefits separate from medical:

- Florida Healthy Kids (CHIP)
- All Florida Government agency employees
- All Florida city and county employees
- Florida State Representatives
- Florida State Senators
- Teachers
- Firefighters
- Police
- All small businesses, large businesses, individuals, and family insurance policies
- Affordable Care Act (ACA) health care exchanges

In addition, the following states have kept dental benefits separate from medical in their Medicaid programs:

- Alabama
- California
- Illinois
- Louisiana
- Maryland
- Massachusetts
- South Carolina

HEADQUARTERS
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E-mail: gao@floridadental.org

FLORIDA DENTAL ASSOCIATION

FOUNDED 1884

- Tennessee
- Texas
- Virginia

The FDA openly invites a continued discussion with AHCA on the independence of Florida's dental managed care program and the pending legislation to exclude dental care from the scope of services under the MMA. Despite the many challenges our members have encountered during the transition to managed care under the PDHP, the FDA would like to see a continuation of the separate payment methodology for Medicaid dental services. This would result in a less complicated system and ensure more tax dollars go toward patient care and less towards program administration. Furthermore, the FDA recommends AHCA establish a Dental Care Advisory Council to help address and ultimately alleviate many of the problems the state has encountered (and will encounter again) during the transition of Medicaid pediatric dental care delivery systems. Additionally, the FDA has recommended numerous times for AHCA to utilize the expertise of a dentist when developing contracts with dental plans. To assist with this, the FDA offers its experienced pool of well qualified, practicing pediatric dentists to assist in this effort.

If you have any questions or need additional information, please contact Casey Stoutamire at cstoutamire@floridadental.org or 850-224-1089.

Sincerely,

Terry L. Buckenheimer DMD

Terry L. Buckenheimer, DMD
President, Florida Dental Association

CC: FDA Board of Trustees
FDA Governmental Action Committee
Drew Eason, FDA Executive Director
Joe Anne Hart, FDA Director of Governmental Affairs

Letter dated October 15, 2013 from Anthony P. Carvalho of the Safety Net Hospital Alliance of Florida.

RECEIVED

OCT 16 2013

AGENCY FOR HEALTH
CARE ADMINSTRATION

Teaching Hospitals
Jackson Health System
Mount Sinai Medical Center
Orlando Health
Shands HealthCare
Shands Jacksonville Medical Center
Tampa General Hospital

Public Hospitals
Halifax Health
Lee Memorial Health System
Memorial Healthcare System
Broward Health
Sarasota Memorial Healthcare System

Children's Hospitals
All Children's Hospital
Miami Children's Hospital

Regional Perinatal Intensive Care Center
Sacred Heart Health System

Anthony Carvalho
President

October 15, 2013

Elizabeth Dudek
Secretary
Florida Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Dear Secretary Dudek:

I am writing to submit comments in support of the Florida Agency for Health Care Administration's (AHCA) request to increase Florida's Low Income Pool Program (LIP). The Safety Net Hospital Alliance of Florida strongly concurs with your draft Waiver Extension Request:

> *"To provide for Florida's Medicaid, underinsured and uninsured populations, the Agency is likely to seek increased funding for the LIP ranging from $3 billion to $5 billion annually, for the upcoming waiver extension period of July 1, 2014 through June 30, 2017. The Agency is seeking to increase the number of Medicaid, underinsured and uninsured to be served through the LIP program."*
> (Pubic Notice Document Waiver Extension Request, October 1, page 51)

These comments are submitted on behalf of the Safety Net Hospital Alliance of Florida members which are Florida's largest teaching, public, and children's hospitals, as well as regional perinatal intensive care centers. Our 14 safety net hospital systems are located in the most densely population areas of the state; but through systems of clinics, affiliate facilities, and transfer agreements, these hospital provide services to patients coast to coast including Florida's rural communities. Our members comprise only 10% of the state's hospitals yet provide 100% of all Level I trauma center admissions, 100% of all ICU burn care, 70% of all organ transplants, 68% of all medical training for physicians, 48% of all pediatric ICU days, 41% of all charity care days and 40% of all Medicaid days in the state.

The Safety Net Hospitals look forward to working with you and the Centers for Medicare and Medicaid Services (CMS) on this critical health care delivery and financing program. While increasing the LIP allotment will not improve Florida's disproportionate share (DSH) allocation, or the DSH ranking as the 4th lowest per capita in the nation; we believe that the LIP increase would afford Florida's uninsured population – the 2nd highest in the nation – a much stronger health care safety net.

Specifically in support of your LIP funding increase request, the Safety Net Hospital Alliance requests that AHCA and CMS consider the following:

A. *Take Advantage of Untapped Local and Hospital Resources*: Increase LIP fiscal cap to $6 billion per year to fully take advantage of untapped fiscal resources at the local and hospital level to increase the numbers of citizens served.

B. *Place Greater Emphasis on Quality and Health Care Delivery Innovations*: Increase LIP funding and allow for expenditures or payments intended to support and reward providers with emphasis on programmatic and quality initiatives designed to improve the provision of health care services to uninsured and underinsured individuals.

C. *Enhance Support for Physician Workforce Training*: Increase LIP funds and allow for additional expenditures and payments for graduate medical education initiatives to support and reward enhancements and innovations in graduate medical education and the access to care those providers can offer while in training and afterwards.

D. *Use Greater Flexibility in Financing*: Maintain and utilize the Waiver Authority to implement Certified Public Expenditures (CPE) funded support for public hospitals as already allowable under Florida's current 1115 Medicaid Reform Pilot Waiver.

As you know, our hospitals have committed significant resources to improve the quality of care, and enhance access to health care services to vulnerable and low-income populations. By virtue of our mission, safety net hospitals will continue to provide the majority of the state's care to the uninsured and Medicaid enrollees. By increasing the allowable LIP funding, Florida Safety Net Hospitals will be able to keep our mission's strong.

Sincerely,

Anthony P. Carvalho
President

cc: Florida Congressional Delegation

Sent: Friday, October 11, 2013 5:10 PM
To: FLMedicaidWaivers
Subject: 1115 MMA FHA Comments

Attached is the FHA comment letter. Please advise if you have any questions. – e

---
Ellen N. Anderson

October 11th, 2013

Mr. Justin Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration

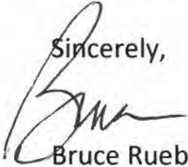
Via E-Mail

Dear Mr. Senior,

On behalf of our 238 members, we would like to take this opportunity to express our sincere gratitude for working with us as the state moves forward with the 1115 Managed Medical Assistance Waiver. The Florida Hospital Association supports the implementation of Statewide Medicaid Managed Care. As you are aware, Florida currently has the second highest percentage of uninsured in the nation (4 million). Despite the high number of uninsured, our state receives a disproportionately low amount of federal funding for services delivered to this low-income population.

We look forward to working with you.

Sincerely,



Bruce Rueben
President

Sent: Friday, October 11, 2013 2:33 PM
To: FLMedicaidManagedCare
Subject: For AHCA and CMS consideration

For AHCA and CMS to consider regarding the 115 Waiver Extension Request

Thank you,

Sean Schwinghammer

Oct 11, 2012

115 MMA Wavier Extension Request Coordinator
Office of Deputy Secretary of Medicaid
Agency for Health care Administration
2727 Mahan Drive,
MS#8
Tallahassee FL, 32308

RE: **Concerns Over the Pharmacy Benefit and Managed Outsourcing of Pharmacy to Medicaid Patients**

Dear Mr. Senior and CMS staff,

As the State of Florida is in negotiations with the Centers for Medicare and Medicaid Services regarding the waiver to allow the full implementation of Medicaid reform, we feel it is important to make clear our concerns that the move of nearly three million patients into managed care can have negative effects on patients' pharmacy care benefit. Below we will explain situations of concern and offer solutions which pharmacy experts in Florida deem necessary to protect Florida Medicaid patients and the Florida tax payer.

Pharmacy Access - To protect Medicaid patients' 'access to pharmacy care' there is a reported proximity requirement; that all MCOs must have in their network a pharmacy no farther than 10 miles from any patient. That standard is ineffective and does not address the choice issue. 10 miles, in urban areas, is useless, as there could be 10 pharmacies within a mile. What must be in any agreement is that patients can access any retail pharmacy licensed under Medicaid. Restrictions to chain stores, super market pharmacies or preferred networks, will limit patient access from a pharmacy of the patient's choice and might limit service.

The distance measure is also 'as the crow flies'. For many that discounts access via a bus stop, or the closest within walking distance. That type of variety is necessary especially in a state as diverse as Florida, with rural, suburban and urban areas.

Specialty Pharmacies, and those with owner pharmacist, are known for providing a higher quality of care and for spending more time with the patients. This is necessary as patients need to fully understand the complex interaction of various medications. In most cases a patient sees their pharmacist more than their doctors, so access to the pharmacist of their choice is vital.

15455 West Dixie Highway. Suite F. North Miami Beach, Florida 33162 – (305) 948 6429

Preferred Networks - Preferred Networks are a growing problem related to the operations of managed care organization's pharmacy benefit. Preferred Networks are sales tools used by Pharmacy Benefit Managers (middle men hired by insurance companies to control their pharmacy benefit). They are advertised to patients suggesting the patients can save money if they use a particular chain of stores. Often, co-pays are reduced in Preferred Networks, as an incentive to drive sales of other retail products, such a groceries. In Medicaid reform most patients will not have to pay co-pays, but to satisfy alliances, PBMs are already attempting to steer patients to the Preferred Networks.

As Medicaid is paid for by state and federal dollars, no restrictions should be made, nor should excessive incentives be allowed, to draw patients from one Florida owned business to another. Medicaid providers cannot be allowed to use the program to drive retail sales or corporate profits at the expense of Florida businesses, but more importantly and at cost in time or money of Medicaid Patients. All pharmacies should be treated equally and given the same access rights and incentives.

Manufacture Rebates -Based on volume purchasing and the ability to direct customers, Pharmacy Benefit Managers get rebates from drug manufactures. Those rebates and other incentives increase PBM profits but do nothing to help the patient nor tax payer. AHCA should request, and CMS should require, that PBMs be transparent regarding the rebates and incentives from manufactures and those discounts derived from use of their in-house mail order programs. The success of mandating transparent PBM programs has been proven, nationwide generating money's for the program and end users. The state can use this information in its yearly re-negotiation of program pricing. As this is a Medicaid program those money's should be reinvested in the program to either assist patients or should be returned to the tax payer.

Mail Order -It is important to save money in all programs. One tool used by some managed care organizations is 'Mail Order', in which prescription drugs are mailed to patients. Mail order has become the primary way to distribute drugs under many insurance policies, including the state of Florida's employee health plan. This has caused great consternation among recipients. It should be mandated by CMS that Mail Order can only be an option for patients, not a mandate for them. In addition, the co-pay (if any) and the months' supply to be dispensed at onetime, should be equal for both mail order and retail pharmacy. This will maximize the benefit for patients, at no cost to the state or the MCO.

Pharmacy is a vital and expanding portion of health care, especially for the Medicaid population. It is vital that all aspects of pharmacy be accessible to patients.

AWP - The State of Florida has in its Medicaid Reform law a provision that requires each insurance company to contract with any medical equipment provider that meets the standard Medicaid licensing criteria and agrees to the price for the service. That price should be a fair price. There is a large national company, that has contracts with every major Managed Care Organization in the State, they have been driving down the price for all service by offering take it or leave it contracts that feature prices below the actual cost of services and would require services be delivered below the minimum wage. We request that CMS require the law be followed, in addition, that published minimums be set for home care prices and services to assure that private contracts not be made that will endanger the health of patients and will not hide profits, which should belong to the Florida tax payer.

Thank you for your consideration of the points above. As a family run company working in Pharmacy and home based care health since 1957, we have been a witness and participant to every evolution in modern health care. We are confident that our suggestions will help to smooth out the definite rough spots that will arise with such a major transfer of power in Medicaid.

Good luck to you

Sincerely,

Sean Schwinghammer
Director of Business Development
SurfMed, Pharmacy and DME supply

Sent: Friday, October 11, 2013 3:48 PM
To: FLMedicaidWaivers
Subject: 1115 MMA waiver extension request

COMMENTS AND SUGGESTIONS:

I would recommend the following changes;

- AHCA should consider a change in the contract procurement requirements for contracts under the MMA waiver should include incentives for managed care organizations that can demonstrate innovative approaches to funding the Medicaid Assistive Care Services supports necessary to ensure that adults with mental illness can remain in licensed limited mental health assisted living facilities.

Rationale:

1. Due to chronic low rates for Medicaid Assistive Care Services ($9.28/day) many adults with serious mental illnesses who also have emerging medical needs or rising acuity are prematurely discharged to a more restrictive placement such as a state hospital or nursing home because the rates are inadequate to ensure a level of quality of care and services.

2. The managed care companies do not offer a reimbursement rate that ties to level of functional impair such as found in the tiered payment models used in 17 other states or the DRG funding method used for hospitals in Florida. Because we have no connect between payment and need only the persons with moderate needs can be served in a limited mental health ALF.

3. The recent newspaper reports in the Miami Herald underscore the rapid rise of unlicensed ALFs that are emerging throughout Florida. This is where adults with serious mental illnesses are being referred especially those with emerging medical needs who cannot get access to a licensed limited mental health ALF that offers protections under the resident bill of rights.

4. Mental health and violence is a major issue that substantially affects public safety. it is estimated that 90% of the nearly 6300 adults with serious mental illness who reside in limited mental health ALFs have schizophrenia. The need for stable housing paired with access to stable services is essential.

5. The data from AHCA shows there is a decline in the number of ALF providers willing to accept a Medicaid Assistive Care Services Program resident. The loss of residential capacity places many of these individuals into unstable living arrangements with little to no oversight and dramatically increases the potential for random acts of violence. The need for greater investment in stable housing or living arrangements is paramount to avoid the need for institutional costs such as jail, hospital ER and premature nursing home placement.

6. There are no incentives in the current procurement documents that would provide the managed care plans with any incentives to address these quality issues with the adversely affected subgroup population of adults with schizophrenia. In fact quite the opposite is true that the managed care company has greater incentive not to address the quality issues associated with access to licensed and

stable ALF care because once these people drift into unlicensed facilities, homeless shelters or move into the streets or the woods they substantially reduce their demand for Medicaid services.

7. Many hospitals are discharging the adults with serious mental illnesses into unlicensed ALFs, homeless shelters that offer no protections under the resident bill of rights found under FS 429.28(1). This places these vulnerable adults at risk of exploitation, abuse and self neglect.

8. In 2010 the DCF reported that 79,000 adults were served and had at least two mental health services and reported living with a family friend or relative. Of this population 614 were reported to DCF for self neglect and another 20,000 were baker acted or involuntarily placed in a hospital for stabilization of psychiatric symptoms. This data reflects that for many Floridians mental health care is crisis driven and is poorly coordinated.

9. Many of the providers in the networks will not accept new Medicaid clients. The network sufficiency standards and monitoring of access to networks is inadequate and there is no way to ensure there is adequate access to the providers.

- AHCA should consider a change to its contracts with MMA managed care providers to require that the each managed care organization to offer a tiered payment approach that will help encourage resident retention, allow for aging in place of aging adults with serious mental illnesses and to allow residents to receive the support needed to avoid or delay unnecessary migration to skilled nursing homes, incarceration or frequent hospitalizations.

1. It is estimated that 17 other states use a tiered payment system to ensure that funding is connected to the level of need.

2. It is estimated that the diagnosis of "psychosis" is the number three top diagnosis in Florida ERs. This reflects a high level of utilization by the mentally ill to access basic or emergency services.

3. There is a growing number of adults with mental illness in the nursing homes, jails, homeless shelters and in unlicensed ALF. There is no stable system of care available for these individuals.

- AHCA should consider making changes to the risk adjusted rates for the adults with serious mental illnesses (6,300 individuals) who reside in licensed limited mental health assisted living facilities. The proposed rates should be utilized to correct deficiencies in rates associated with allowing adults with mental illness to age in place and receive the level of support services needed to avoid premature placement in nursing homes, jails or frequent hospitalizations. The problem is that the incentives associated under the current waiver are inadequate to make the needed changes at the micro economic level for adversely affected subgroups such as individuals with schizophrenia and schizoaffective disorder.
  1. The managed care companies report that they lose money serving the residents of limited mental health ALFs.

  2. There are no incentives available that would ensure that residents with a mental illness who have rising medical needs can remain in a licensed limited mental health ALF due to chronic low rates.

Sent: Saturday, October 05, 2013 1:27 AM
To: FLMedicaidWaivers
Subject: comments on 115 wavier

Comments on 115 waiver:

I have read over the 115 wavier and only one instance are Nurse Practitioners mentioned. It seems that the entire document is written as physician specific. This language will not allow NPs and PAs to participate.

This will only add to the difficulty in getting PAs and NP empanelled with HMO's. I have suggest many changes that allows NPs and PAs to see medicaid patients.

These suggestion if placed in the final document will encourage the HMOs to look for all types of providers not just physicians.

See attached.

Thank You for the opportunity to comment.

Stan Whittaker ARNP, MSN

Sent: Thursday, October 03, 2013 3:42 PM
To: FLMedicaidWaivers
Subject: RE: Request for Extension of the 1115 Managed Medical Assistance Waiver

Do you know what this is about?

Sent: Wednesday, October 02, 2013 11:05 AM
To: 'Henry Parra'; 'Seller99'; 'Aisha Jones'; 'Denise'; 'Gail Matillo'; 'Lee Ann Griffin'; 'Pat Lange'; 'Susan Langston';
Subject: FW: Request for Extension of the 1115 Managed Medical Assistance Waiver

ALF Friends

I am forwarding this meeting notice regarding the MMA waiver to you so that you can provide input to the AHCA regarding the necessary changes needed to help address the chronic and systemic problem of underfunding the care of mental health residents who reside in licensed limited mental health ALFs.

I would recommend the following changes;

- AHCA should consider a change in the contract procurement requirements for contracts under the MMA waiver should include incentives for managed care organizations that can demonstrate innovative approaches to funding the Medicaid Assistive Care Services supports necessary to ensure that adults with mental illness can remain in licensed limited mental health assisted living facilities.

- AHCA should consider a change to its contracts with MMA managed care providers to require that the each managed care organization to offer a tiered payment approach that will help encourage resident retention, allow for aging in place of aging adults with serious mental illnesses and to allow residents to receive the support needed to avoid or delay unnecessary migration to skilled nursing homes, incarceration or frequent hospitalizations.

- AHCA should consider making changes to the risk adjusted rates for the adults with serious mental illnesses (6,300 individuals) who reside in licensed limited mental health assisted living facilities. The proposed rates should be utilized to correct deficiencies in rates associated with allowing adults with mental illness to age in place and receive the level of support services needed to avoid premature placement in nursing homes, jails or frequent hospitalizations. The problem is that the incentives associated under the current waiver are inadequate to make the needed changes at the micro economic level for adversely affected subgroups such as individuals with schizophrenia and schizoaffective disorder.

I have detailed below for you some facts about the Medicaid funding for the limited mental health ALF population. I hope this is helpful as you work to advocate for better funding for care and more efficient approach to the management of the care and services needed by our residents.

Doug

- The current rate for ACS services is $9.28/day
- This rate has not changed since 2001
- If the rate kept pace with inflation it would now be $12.76/day
- Current rate in 2013 dollars is only worth $7.30/day in 2001 dollars.
- In 2010 the budget for Medicaid Assistive Care Services was reduced from $32 million to $25 million one of the largest social services cuts.
- The average amount that actually goes into the care of a state funded limited mental health resident is $5.76
- Work has been done by HMA to recommend to AHCA to include language in the Medicaid Reform plans that would ensure that managed care contractors make changes or have incentives to make changes to how limited mental health ALFs are funded.
- The Medicaid Reform contracts for long term care and MMA plans have not provided much room to negotiate the rates and no changes are expected other than a duplication of what already is happening.
- There are no incentives built into the Medicaid Reform contracts for Medicaid HMOs to make changes to the rates with LMH ALFs.
- The Medicaid HMOs report that the risk adjusted rates are too low and they lose money on the LMH ALF population because they are high end users of services.
- Residents in LMH ALF have additional civil rights under FS 429.28(1)(j) to access adequate and appropriate health care, which creates a need for greater access to services. If a facility cannot access the services needed then they are forced to discharge the resident by law.
- Florida is the lowest funded state in the nation for Medicaid Assistive Care Services.
- The number of facilities that are enrolled and serving Medicaid ACS residents has been steadily declining over the last few years due to rates.

- There are approximately 9,000 adults with schizophrenia or schizoaffective disorders who reside in the LMH licensed facilities. There are 6300 Medicaid clients and 2900 non Medicaid residents.
- There are 1000 state licensed limited mental health ALFs – only 459 have a LMH only license which would signal they serve the adult mental health population.
- 85% of incidents that involve people with mental illness and violence happen with people who are diagnosed with schizophrenia or schizoaffective disorders.
- According to DCF there are 20,000 adults with a diagnosis of schizophrenia or schizoaffective disorders in Florida's mental health system.
- The Medicaid data shows that there was $71 million spent on the care of adults with a serious mental illness who reside in a LMH ALF.
- The Medicaid data shows that the LMH ALF only receives 13% of the total Medicaid expended while the CMHCs receive 58% of the total funds.
- Access to stable housing paired with stable services are the keys to reducing the need for deep end hospital care or institutional care.
- According to DCF data 72,996 individuals who are served in the public mental health system reported living on their own or with a friend or family member, of that number 614 were reported to DCF for suspected abuse, neglect or exploitation, of this number 20,417 were baker acted in the fiscal years 2009-2010. This data reflects a crisis driven system of care.
- The AHCA reports according to a recent Miami Herald article an almost 60% increase in the reports of unlicensed ALFs. The reason that unlicensed ALFs are growing is because there is no good economic reason to operate a licensed ALF that would serve low income adults with a mental illness. The marketplace is upside down and is in decline.

Sent: Tuesday, October 01, 2013 5:30 PM
To: FLMedicaidWaivers
Subject: Re: Request for Extension of the 1115 Managed Medical Assistance Waiver

Don't understand what this is...