Florida
MEDS-AD Waiver

4th Quarter Report
October 1, 2015 – December 31, 2015
Demonstration Year 10

1115 Research and
Demonstration Waiver
#11-W-00205/4

This page intentionally left blank

Table of Contents

List of Tables

This page intentionally left blank

I. Introduction

This report includes programmatic and financial activities for the period October 1, 2015 through December 31, 2015. By implementing Florida's 1115 MEDS-AD waiver (MEDS-AD waiver), the Agency for Health Care Administration (Agency) seeks to demonstrate that the total cost of providing access to care for the MEDS-AD population (including costs for the Medication Therapy Management (MTM) program) will not exceed expected long-term cost of care for these individuals had they not received coverage until they required institutional care.

II. Budget Neutrality Update

The following table compares actual MEDS-AD waiver expenditures to the costs projected for this population had the MEDS-AD waiver not been granted. To date, actual expenditures have been below the projected cost.

Table 1
Budget Neutrality
MEDS-AD Waiver

Demo Year	Quarter Ended	With Waiver Expenditures ($)*	With Waiver Expenditures Cumulative Total ($)	Without Waiver (Target) Expenditures ($)	Without Waiver Expend Total ($)	Difference ($)	Cumulative Difference ($)
DY1	Q1	51,696,950		507,710,894		456,013,944	
	Q2	132,235,096		507,710,894		375,475,798	
	Q3	105,271,113		507,710,894		402,439,781	
	Q4	146,356,839	435,559,998	507,710,894	2,030,843,575	361,354,055	1,595,283,577
DY2	Q5	69,927,763		460,700,626		390,772,863	
	Q6	79,047,475		460,700,626		381,653,151	
	Q7	87,567,517		460,700,626		373,133,109	
	Q8	90,210,963	762,313,716	460,700,626	3,873,646,079	370,489,663	3,111,332,363
DY3	Q9	93,882,619		455,999,599		362,116,980	
	Q10	103,108,178		455,999,599		352,891,421	
	Q11	95,761,142		455,999,599		360,238,457	
	Q12	96,128,169	1,151,193,824	455,999,599	5,697,644,476	359,871,430	4,546,450,652
DY4	Q13	107,727,900		465,401,653		357,673,753	
	Q14	106,365,677		465,401,653		359,035,976	
	Q15	120,849,499		465,401,653		344,552,154	
	Q16	133,665,863	1,619,802,762	465,401,653	7,559,251,086	331,735,790	5,939,448,324
DY5	Q17	138,153,082		460,700,626		322,547,544	
	Q18	144,229,555		460,700,626		316,471,071	
	Q19	134,966,909		460,700,626		325,733,717	
	Q20	148,599,566	2,185,751,874	460,700,626	9,402,053,590	312,101,060	7,216,301,716
DY6	Q21	154,004,876		**			
	Q22	146,340,361		**			
	Q23	155,268,617		**			

Table 1
Budget Neutrality
MEDS-AD Waiver

Demo Year	Quarter Ended	With Waiver Expenditures ($)*	With Waiver Expenditures Cumulative Total ($)	Without Waiver (Target) Expenditures ($)	Without Waiver Expend Total ($)	Difference ($)	Cumulative Difference ($)
	Q24	163,774,246	2,805,139,974	**	9,402,053,590		6,596,913,616
DY7	Q25	165,396,338		**			
	Q26	184,629,761		**			
	Q27	165,063,579		**			
	Q28	168,922,270	3,489,151,922	**	9,402,053,590		5,912,901,668
DY8	Q29	151,084,893		**			
	Q30	150,685,372		**			
	Q31	159,986,109		**			
	Q32	165,422,402	4,116,330,697	**	9,402,053,590		5,285,722,893
DY9	Q33	164,516,691		**			
	Q34	161,043,862		**			
	Q35	147,278,798		**			
	Q36	124,678,137	4,713,848,186	**	9,402,053,590		4,688,205,404
DY10	Q37	134,213,827		**			
	Q38	113,860,203		**			
	Q39	113,106,218	5,075,028,434	**	9,402,053,590		4,327,025,156
	Q40	115,046,182	5,190,074,616	**	9,402,053,590		4,211,978,974

*These are based on dates of payment expenditures for the MEDS-AD waiver reported within the CMS64, which could get distributed across the demonstration years.

**The original without waiver expenditure ceiling was not increased with the renewal period beginning in Quarter 21. The $7,216,301,716 cumulative difference between the approved budget neutrality ceiling and actual waiver expenditures as of the end of the original demonstration period on December 31, 2010, was allocated across the 12 renewal quarters as the new expenditure ceiling.

III. Operational Update

1. Eligibility and Enrollment

The Florida Department of Children and Families is responsible for conducting intake, assessment, eligibility determination, enrollment, disenrollment, and data collection on the availability of third-party coverage, including Medicare, and annual re-determinations of eligibility.

To be eligible for the MEDS-AD waiver, recipients must be at or below 88% of the federal poverty level (FPL) with assets at or below $5,000 for an individual ($6,000 for a couple) and be in one of the following Florida Medicaid eligibility groups (MEGs):

- **MEG 1 (MA-Medicaid Only):** Florida Medicaid-only eligibles not currently receiving institutional care services, hospice services, or home and community-based services.

- **MEG 2 (MA-Medicaid Institutional):** Florida Medicaid-only eligibles currently receiving institutional care services, hospice services, or home and community-based services.

- **MEG 3 (MA-Dual Eligibles):** Florida Medicaid and Medicare (dual) eligibles receiving Florida Medicaid-covered institutional care services, hospice services, or home and community-based services.

Most individuals in MEG 1 must select a Managed Medical Assistance (MMA) plan in their region. If the recipient does not select an MMA plan they will be assigned to one. Information on the MMA program can be found on the Agency's Web site at the following link: http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml.

Table 2 details the monthly total count of individuals enrolled through the MEDS-AD waiver for this reporting period (October 1, 2015 through December 31, 2015).

Table 2
MEDS-AD Waiver Enrollment
October 1, 2015 – December 31, 2015

Month	Total Enrollment*
October 2015	45,875
November 2015	45,556
December 2015	44,890

*Total enrollment counts are revised for retroactive eligibility determinations, and therefore may change from one reporting period to the next.

2. Comprehensive Medication Reviews

The comprehensive medication review focuses on the MEG 1 fee-for-service group within the MEDS-AD waiver, as these individuals are not receiving institutional care and are not enrolled in a managed care plan. The process includes an initial direct telephone contact to a recipient from medically trained staff (which may include nurses, pharmacists, clinical associates, etc.) who explain the review process and invite the recipient to participate in a comprehensive medication review (CMR) with a pharmacist (covering all prescription, over-the-counter, herbal, and other medications and chronic diseases). If the recipient agrees, a call with a case reviewer is scheduled for performance of an annual CMR. A Personalized Medication List and a Medication Action Plan is then developed and mailed to the participating recipients. As part of the services, prescribers are notified of potential issues or problems via phone and/or facsimile, depending on the urgency of the issue, following the review. Quarterly follow-up reviews of the patient health information and claims history are performed to track the result of the review and feedback to the prescriber. The patient and prescriber are contacted again if issues or risks are identified. Recipients are given the option at the end of the year of participation in the program to continue into the next year.

Please see Attachment A for a detailed progress report prepared by the University of Florida (UF) providing all case review activities for the period October 1, 2015 through December 31, 2015. This report includes details of case review statuses, patient specific intervention results, listing of interventions faxed to prescribers, and a tabulation of the results of the interventions by clinical category.

3. Data Mining Activities

The current status of initiatives resulting from the data mining activities approved through the MEDS-AD waiver for the period October 1, 2015 through December 31, 2015, is as follows:

- The Medicaid Fraud Control Unit (MFCU) opened one new complaint:
    - Under Data Mining Analyst Report (DMAR)-19
- MFCU closed four complaints :
    - One under DMAR-32 referred to AHCA/MPI
    - One under DMAR-19 as consolidated to an existing case
    - One under DMAR-074 opened to a case for further investigation
    - One under DMAR-070 opened to a case for further investigation
- MFCU closed two cases with the following results:
    - DMAR-019 – closed as Consolidated
    - DMAR-018 – closed as Unfounded

IV. Evaluation Activity

1. Evaluation Requirements

The Agency continues to contract with Florida State University (FSU) to conduct an independent evaluation of the MTM program and data mining activities to cover the demonstration period for the MEDS-AD Waiver.

The original evaluation plan for the MEDS-AD Waiver was submitted to the Centers for Medicare and Medicaid Services (CMS) on April 29, 2011. No deficiencies were noted, and the evaluation activities are proceeding as planned.

2. MEDS-AD MTM Program Description, Design, and Initial Findings

The MTM program, implemented by UF's College of Pharmacy (COP), uses high-intensity pharmacy case management services in conjunction with access to appropriate medical care for select individuals who are elderly or who have a disability as a way to maintain care in the community and prevent premature institutionalization. The program is to be budget-neutral and incorporate innovative service concepts. The Special Terms and Conditions of the MEDS-AD waiver require that the total cost of medical services and MTM for persons who are enrolled in the MEDS-AD waiver be compared with the estimated cost of institutional care that is avoided.

The quantitative analysis of the MTM program includes a thorough examination of many health, utilization, and financial outcomes potentially influenced by the MTM intervention. The qualitative analysis includes semi-structured interviews with UF COP pharmacists and approximately 20 randomly selected MTM participants.

A preliminary final evaluation report of the MEDS-AD Waiver MTM Program was received in December 2015. This report summarizes the preliminary findings of the pre-intervention periods (June 1, 2010 through May 31, 2014) and their respective MTM intervention years (June 1, 2011 through December 31, 2014) for four cohorts of MTM participants. A preliminary finding that appears to have approached significance indicates the mean total expenditures per person declined more in the intervention (MTM program participant) group than in a comparison group

of non-participants. More complete and final results for both the quantitative and qualitative analyses will be presented when the final evaluation report is received in February 2016.

3. Medicaid Fraud Control Unit Evaluation Component

The goal of the Data Mining Initiative (DMI) under the MEDS-AD waiver is to determine if data mining activities by the Office of the Attorney General-Medicaid Fraud Control Unit (OAG-MFCU), in conjunction with the Agency's Bureau of Medicaid Program Integrity (MPI), result in the recovery of Florida Medicaid funds paid as a result of fraudulent or abusive billing. In Florida, the investigation of suspected Florida Medicaid fraud is under the auspices of the OAG-MFCU, whereas cases of suspected abuse of the Florida Medicaid program are handled by the Agency's MPI unit.

The evaluation of the MEDS-AD waiver also includes the evaluation of data mining in terms of recoveries and costs. Specifically, the evaluation is required to determine if the data mining-related recoveries or measurable cost avoidance are directly attributable to analyses performed by analysts from OAG-MFCU and MPI.

The evaluation's quantitative analysis includes comparing pre and post-intervention periods for the number of case files initiated, action taken, amount recovered, fraud-related convictions, and time to case resolution. Qualitative analysis includes key informant interviews with programmers, data analysts and administrators in OAG-MFCU and MPI to identify recommendations for increasing the efficiency and effectiveness of the data mining process leading to successful identification and recovery of inappropriate Florida Medicaid payments.

A preliminary evaluation report of Data Mining Activities was approved by the Agency on November 24, 2015. The preliminary report indicates there has been an increase in the number of complaints and in the number of complaints being converted to full case investigations. Preliminary findings suggest that the intentions of the DMI are being met. More detailed and complete findings will be presented when the final evaluation report is received by the Agency in February 2016.

V. Waiver History

1. Legislative Changes

In 2005, concurrent with federal Medicare Part D implementation, the Florida Legislature amended the statutory eligibility criteria for the MEDS-AD program and directed the Agency, in Chapter 2005-60, Laws of Florida, to seek federal waiver authority to revise Florida Medicaid eligibility coverage for the Florida Medicaid MEDS-AD eligibility group beginning January 1, 2006. The eligibility changes to the MEDS-AD program maintained eligibility for qualified recipients without Medicare coverage and eliminated coverage for dually eligible individuals unless the person is eligible for and receiving Florida Medicaid hospice services, home and community-based services, or institutional care services.

2. Program Design

To implement the Legislative changes described above, the State amended Florida Medicaid's State Plan to eliminate the former MEDS-AD eligibility category and submitted an 1115 research

and demonstration waiver for aged or disabled residents of the State of Florida with incomes at or below 88% of the FPL and assets at or below $5,000 for an individual and $6,000 for a couple. Coverage is limited to those aged and disabled persons who are either receiving or elect to receive hospice services, home and community-based services, or institutional care services or who are not eligible for Medicare. The MEDS-AD program is designed to prevent premature institutionalization of these vulnerable individuals by maintaining their level of care in the community longer through the provision of:

- Access to health care services
- Medication therapy management

The continued coverage, as well as the MTM program, will be funded through savings obtained by avoiding institutional costs that would otherwise occur in the next five years had these vulnerable individuals been denied access to prescribed drugs and other medical services. The focus of the demonstration is to provide MTM for enrollees who are not yet receiving institutional care.

3. Waiver Extension

In December 2010, the State received approval from CMS for the renewal period January 1, 2011 through December 31, 2013. On June 28, 2013, the State submitted a renewal request under 1115(a) authority to extend the MEDS-AD waiver through December 31, 2016. The Centers for Medicare and Medicaid Services granted the State a one-year temporary extension on August 14, 2013 extending the current waiver period to December 31, 2014.

The State received a second one-year temporary extension on November 1, 2014, to extend the MEDS-AD waiver until December 31, 2015.

On June 30, 2015 the State submitted a 3-year extension request for the period January 1, 2016 through December 31, 2018. The State received a temporary extension on December 8, 2015, to extend the MEDS-AD waiver until February 29, 2016. See Attachment B for a copy of the letter from CMS granting the temporary extension.

4. Maintenance of Effort (MOE) Provisions in Section 1902(a)(74) and 1902(gg)

Since the MEDS-AD waiver was renewed by CMS after March 23, 2010, it is no longer subject to the MOE provisions of the Affordable Care Act.

Attachment A
Case Review Activity Report
October 1, 2015 – December 31, 2015

Reporting for Quarter 2: October 1, 2015 to December 30, 2015

***Attached Documents*:**

1. **Implementation Plan** detailing the progress of each program task and identifying any current/possible barriers to the completion of identified program tasks
2. **Quarterly Report**

Pertinent Abbreviations:

Appt = Appointment
CMR = Comprehensive Medication Review
MTMCCC = Medication Therapy Management Communication and Care Center
MAP = Medication Action Plan

1. Implementation Plan

A. Progress Report:

Task	*Entity Responsible*	*Start Date*	*Status*
Draft Medicaid Drug Therapy Management Program Contract	AHCA		Completed 02/24/11
Review Medicaid Drug Therapy Management Program Contract	AHCA, UFCOP MTMCCC, UF COP	02/24/11 Amended: 7/16/12	Completed
Sign Medicaid Drug Therapy Management Program Contract	UF COP		Completed 06/01/11; Amended 7/16/12 Amended 3/21/14 Amended 7/02/15 & 8/25/15
Draft Program Implementation Plan	UF COP MTMCCC	02/24/11	Completed
Identify Medicaid Recipients / Candidates for UF COP MTMCCC	AHCA		Completed
Transmit Identified Patients' Information to MTMCCC	AHCA	Ongoing	Completed for 2015
Develop Patient Charting System	UF COP MTMCCC	03/15/11	Completed
Develop MAP and Fax Templates	UF COP MTMCCC	03/15/11	Completed
Develop SOP/Workflow	UF COP MTMCCC	03/15/11	Completed
Train MTMCCC Staff	UF COP MTMCCC	02/23/11	Completed
Schedule CMR Appointments for Recipients/Candidates	UF COP MTMCCC	Upon receipt of patient information from AHCA	Completed for 2015
Ongoing Training of MTMCCC Staff	UF COP MTMCCC	Ongoing	Ongoing
Develop Quality Assurance Program	UF COP MTMCCC	03/31/11	Completed
Submit Documents (Program Agreements, Protocols, Educational Materials and Practice Guidelines)	UF COP MTMCCC		Completed
Approval of Documents Submitted by UF COP MTMCCC	AHCA		Completed
Develop Quarterly Reports	UF COP MTMCCC	Upon conclusion of 1st quarter	Ongoing
Submit Quarterly Reports to AHCA	UF COP MTMCCC	No later than the 15th of each month following the reporting quarter	Ongoing
Submit Quarterly Invoice of Services Rendered	UF COP MTMCCC	No later than the 15th of each month following the reporting quarter	Ongoing
First Annual Survey of Sample Recipients	Non-UF Evaluator	Upon completion of required CMRs per QA program	Completed
Draft Preliminary Evaluation Report Including Survey Information	Non-UF Evaluator	Upon completion of required CMRs per QA program	Completed
Utilize Results From Surveys and Evaluation Report to Implement Corrective Action Plan	UF COP MTMCCC	As needed	Ongoing

B. Current/Possible Barriers to Task Completion Report: No barriers identified

2. Quarterly Report Data

Case Status			
Portion of the Case	***Number Completed***	***Start Date***	***End Date***
CMR	158	*06/01/2015>*	*09/11/2015*
3-Month Quarterly Follow-up Review	158	*09/01/2015*	*11/30/2015*
6-Month Quarterly Follow-up Review	6	*12/01/2015*	*2/28/2016*
9-Month Quarterly Follow-up Review		*03/01/2016*	*5/31/2016*

> No call activity in June 2015 due to preparing to utilize new MTM software for upcoming year; also working on updated contract proposal with possible increase in case load for 2015-2016 year; administrative time needed to train new personnel and update key documents.

Calls Made to Program Participating Patients (Including Failed Attempts)				
Intervention	***Count***			
	1st Quarter	***2nd Quarter***	***3rd Quarter***	***4th Quarter***
CMR Scheduled	205	0		
CMR Completed during Scheduling Call (Live transfer to RPh)	28	0		
Patient Interaction (Non-MTM Service Request/Inquiry)	0	0		
Patient Refused Consultation (During CMR Scheduling or CMR Call)	30	0		
Unable to Reach (Appt Scheduling) - 1st Attempt	528	0		
Unable to Reach (Appt Scheduling) - 2nd Attempt	312	0		
Unable to Reach (Appt Scheduling) - 3rd Attempt	199	0		
Unable to Reach (CMR)	74	0		
30 to 60-day CMR Check-Up	18	67		
Unable to Reach 30-60 Day CMR Check-Up*	5	66		
Quarterly Follow-Up with Encounter	6	10		

Outbound calls are made to patients initially to engage patient in the completion of the Comprehensive Medication Review (CMR). Typically appointments are scheduled, and at the convenience of the patient. If the patient would like to complete the CMR call at the time of scheduling, then the call is live transferred to a pharmacist. Three call attempts (at least) are made to the patient to attempt to schedule and/or complete the CMR. Each patient receives a contact attempt again within 30 to 60 days following the CMR to determine if the patient received all of the mailed materials following the CMR. At the time of the quarterly follow-up review (QR), the patient is called only as necessary and/or when items identified during the CMR or QR require a follow-up conversation with the patient; otherwise, claims data is reviewed and a QR assessment is completed without contacting the patient.

A. Summary of Interventions +

*Patient Specific Interventions**				
CMR/MAP Interventions	*Count*			
	1st Quarter	*2nd Quarter*	*3rd Quarter*	*4th Quarter*
Counseled on Diet/Exercise	16	0	0	0
Counseled on Lifestyle Modifications	14	0	0	0
Counseled on Medication (General, side effects, indication, etc.)	124	0	0	0
Counseled on Medication Adherence/Compliance	28	1	0	0
Counseled on Medication Administration/Technique	16	0	0	0
Counseled on Preventative Screenings/Vaccinations	31	1	0	0
Counseled on Smoking Cessation	34	1	0	0
Counseled on Weight Loss	0	0	0	0
Educated on Asthma/COPD	18	0	0	0
Educated on Coverage Gap	2	0	0	0
Educated on Diabetes	19	0	0	0
Educated on Disease State (Other)	10	0	0	0
Educated on Dyslipidemia	4	0	0	0
Educated on GERD	2	0	0	0
Educated on Heart Failure	7	0	0	0
Educated on Hypertension	32	0	0	0
Explained MTM Program to Patient	158	0	0	0

+ This data reflects initial CMRs that were performed from June 1st through September 11th, 2015.

***** *These include interventions that were documented during a phone conversation with the patient during a CMR well as those in the patient specific MAP. Patient specific interventions are made to patients initially during the completion of the Comprehensive Medication Review (CMR). Each patient receives a contact attempt again within 30 to 60 days following the CMR to determine if the patient received all of the mailed materials following the CMR and patient specific interventions may also be made at this time. During the quarterly follow-up review (QR), the patient is called only as necessary and/or when items identified during the CMR or QR require a follow-up conversation with the patient at which time additional patient specific interventions may be made; otherwise, claims data is reviewed and a QR assessment is completed without contacting the patient.*

*Provider Specific Interventions**				
Fax Intervention	*Count*			
	1st Quarter	*2nd Quarter*	*3rd Quarter*	*4th Quarter*
Adverse Drug Event Identified	13	0		
Alternative Dosage Form Recommended	0	0		
Combination Therapy Recommended (decrease pill burden)	0	0		
Duplicate Therapy Identified	2	1		
Inappropriate Dosage Identified (Too high/too low)	1	0		
Excessive Duration of Therapy Identified	0	0		
Excessive Pill Burden Identified (multiple tablets of lower strength)	0	0		
Gap in Therapy - Diabetic without a Statin	12	0		
Gap in Therapy - Diabetic without an ACE-I or ARB	4	0		
Gap in Therapy - Heart Failure without a Beta-Blocker	2	0		
Gap in Therapy - Heart Failure without an ACE-I or ARB	6	0		
Gap in Therapy - Lack of Controller Medication/Beta-Agonist Overuse in Asthma/COPD	1	0		
Gap in Therapy - Lack of Rescue Medication in Asthma/COPD	3	0		
Gap in Therapy - Long-Term Steroid without Anti-Resorptive Agent	1	0		
Gap in Therapy - Osteoporosis without Anti-Resorptive Agent	5	0		
Gap in Therapy - Potentially Inappropriate Beta-Blocker Selection in Heart Failure	5	0		
Generic Alternative Recommended	0	0		
Insufficient Dosage Identified	0	0		
Insufficient Duration of Therapy Identified	0	0		
Lack of Efficacy Identified	0	0		
Lack of Therapy (Indication) Identified	0	0		
Multiple Pharmacies Identified	0	0		
Multiple Prescribers Identified	1	0		
Needs Preventative Screening / Immunizations	0	0		
Non-Adherence Issue Identified	13	7		
OTC Therapy Recommended	0	0		
Polypharmacy Identified	0	0		
Questionable Narcotic Use Identified	0	0		
Recommended Preferred Drug List Alternative	0	0		
Renal Dosing Recommended	0	0		
Unnecessary Therapy (Lack of Indication) Identified	0	0		

** These include interventions that were communicated to providers either via phone/fax.*

Provider specific interventions are made to providers initially during the completion of the Comprehensive Medication Review (CMR). During the quarterly follow-up review (QR), a complete assessment of the patient's medication history takes place again typically without having to contact the patient. At the time of the QR, claims data is reviewed, problems identified during the CMR are re-assessed to see if a provider has taken any action on the previously identified issues (considered a resolved intervention), and discontinued and/or new medications are assessed to see if new problems have been created from the recent medication changes. Providers are not typically re-contacted by fax about the previously identified problem to allow sufficient time for the provider to assess the issue, determine if the issue is valid based on available data, and/or discuss the potential issue with the patient prior to adjusting therapy (potentially at the next office visit).

B. Tabulation of Interactions by Category

Interactions				
Intervention	*Count**			
	1st Quarter	*2nd Quarter*	*3rd Quarter*	*4th Quarter*
Drug-Age Interaction Identified (Beers List)	0	0		
Drug-Allergy Interaction Identified	0	0		
Drug-Disease Interaction Identified	1	0		
Drug-Food Interaction Identified	0	0		
Drug-Pregnancy Interaction Identified	0	0		
Level 1 Clinically Significant Drug-Drug Interaction Identified	1	0		
Level 2 Clinically Significant Drug-Drug Interaction Identified	2	1		

** These include interventions that may not have been communicated to the provider depending on patient education opportunities. This particular set of interventions may include "system generated" items that may or may not be considered clinically significant, or warrant an intervention by the provider and are therefore handled directly by the pharmacist.*

C. Patient Responses

Patient Response/Rating of CMR						
QA Question		*Total Number of Responses*	*Yes*		*No*	
			Count	*%*	*Count*	*%*
CMR	*Did you find this appointment helpful?*	158	130	82.3	21	13.3
	Did this interview help clarify any concerns you may have had with your medications?		112	70.9	35	22.2
30-60 Day Check-Up	*Did you find the mailed documents to be helpful?*	53	45	84.9	8	15.1
	Did participating in the phone call increase your understanding of your medication regimen?	53	45	84.9	8	15.1

D. Provider Responses

Provider Responses								
*Intervention**	*Identified Quarter*				*Resolved Quarter*			*Resolution Rate*
	1	2	3	4	2	3	4	
Adverse Drug Event	13	0			3			
Alternative Dosage Form	0	0			0			
Combination Therapy Recommendation (decreased pill burden)	0	0			0			
Drug-Age Interaction	0	0			0			
Drug-Disease Interaction	1	0			0			
Duplicate Therapy	2	0			2			
Inappropriate Dosage (Too high/too low)	1	1			0			
Excessive Duration of Therapy	0	0			0			
Formulary Alternative Recommendation	0	0			0			
Gap in Therapy - Diabetic without a Statin	12	0			1			
Gap in Therapy - Diabetic without an ACE-I or ARB	4	0			0			
Gap in Therapy - Heart Failure without a Beta-Blocker	2	0			2			
Gap in Therapy - Heart Failure without an ACE-I or ARB	6	0			2			
Gap in Therapy - Lack of Controller Inhaler/Beta-Agonist Overuse in Asthma/COPD	1	0			0			
Gap in Therapy - Lack of Rescue Medication in Asthma/COPD	3	0			1			
Gap in Therapy - Long-Term Steroid without Anti-Resorptive Agent	1	0			0			
Gap in Therapy - Osteoporosis without Anti-Resorptive Agent	5	0			0			
Gap in Therapy - Potentially Inappropriate Beta-Blocker Selection in Heart Failure	5	0			1			
Insufficient Dosage	0	0			0			
Insufficient Duration of Therapy	0	0			0			
Lack of Efficacy	0	0			0			
Lack of Therapy (Indication)	0	0			0			
Level 1 Clinically Significant Drug-Drug Interaction	1	1			1			
Level 2 Clinically Significant Drug-Drug Interaction	2	0			1			
Multiple Pharmacies	0	0			0			
Multiple Prescribers	1	0			1			
Non-Adherence Issue	13	7			6			
Pill Burden	0	0			0			
Polypharmacy	0	0			0			
Preventative Screening/Immunizations	0	0			0			
Questionable Narcotic Use	0	0			0			
Renal Dosing Recommendation	0	0			0			
Unnecessary Therapy (Lack of Indication) Identified	0	0			0			
Total				82			21	
Year Four Program Overall Resolution Rate								***25.6%***

** The intervention was considered resolved when either an appropriate medication was added, discontinued, or changed that resolved the previously identified issue based on the pharmacist's recommendation.*

A resolved intervention defined as: a problem that is identified by the pharmacist upon which the provider takes an action based on the pharmacist's recommendation. The problem is considered resolved once a medication change occurs for the problem identified and is confirmed by a change in prescription claims data for the patient [Ex: Gap in therapy: Diabetic patient not on a statin--Pharmacist notifies the provider that the patient is diabetic and not currently on statin therapy. The provider agrees that this information is true and prescribes a statin for the patient. The pharmacy claims system now shows a fill for a statin medication on the patient's medication profile in the pharmacy claims system. This is now considered a resolved intervention.] Resolution rate is the total number of resolved interventions divided by the total number of problems identified then multiplied by 100%. Many factors influence the resolution rate such as: the provider's actual receipt of the phone and/or facsimile communication; the provider agreeing with the pharmacist recommendation and subsequently taking action on the recommendation; the pharmacist having correct information to make an informed recommendation.

Attachment B
Temporary Extension

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

DEC 0 8 2015

Justin Senior
Deputy Secretary for Medicaid
Florida Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 8
Tallahassee, FL 32308

Dear Mr. Senior:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of Florida's MEDS-AD (Project No. 11-W-00205/4) section 1115 demonstration through February 29, 2016. This temporary extension will allow the state and CMS to continue working together on approval of the MEDS-AD demonstration extension.

The demonstration will continue to operate under the authority of section 1115(a) of the Social Security Act. Additionally, the current list of expenditure authorities and Special Terms and Conditions will continue to apply to the MEDS-AD demonstration until February 29, 2016.

If you have any questions, please contact your project officer, Ms. Dina Payne. Ms. Payne can be reached at (410) 786-3574 or at dina.payne1@cms.hhs.gov.

We look forward to continuing to work with you and your staff on this demonstration.

Sincerely,

Eliot Fishman
Director

cc: Jackie Glaze, Associate Regional Administrator, Region IV

This page intentionally left blank.

State of Florida
Rick Scott, Governor

Agency for Health Care Administration
Elizabeth Dudek, Secretary

2727 Mahan Drive
Tallahassee, FL 32308
ahca.myflorida.com

Mission Statement
Better Healthcare for All Floridians.