From: Brandi Geoit
Sent: Thursday, October 20, 2016 12:22 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: 1115 MMA Waiver extension

I just finished the webinar and I have a comment about the Express Enrollment. You cannot choose a plan through the DCF website and you are automatically and randomly assigned. There is no option to express enroll at this time.

Will there actually be punishments for the MMA plans that keep denying covered benefits such as nutritional supplements. We have one HMO that has a policy to deny it and hope that they do not get appealed. At what point in time does AHCA start punishing the plans that do this?

How is AHCA guaranteeing a patients right to choose when the MMA is mandating that the patients be enrolled into a mail order pharmacy. This clearly violates a patients right to choose where they get their meds from and has caused a barrier to access of medications for patients. I understand that this is used to save money but making a barrier to medications is not saving money it is putting patients lives at risk. Clear Health Alliance and Prestige mandate the mail order and have put it on their websites.

The MMA's have a list of providers that are supposed to be taking them. I have spent hours on the phones for clients only to discover that no one on that list takes the plan. Then I have discovered that the nearest doctor is 2 hours away. The plans said that they did their jobs and listed doctors it is not their fault that the providers no longer participate with them. What will AHCA do about this.

LTC plans telling people that they must enroll with them and scaring patients. I have had a lot of people getting calls from Sunshine and they are being told that if they do not enroll they will lose their benefits. This is clearly patient intimidation and predatory behavior. I have had to explain that the client is on Waiver and does not need to enroll in LTC and cannot enroll in LTC and have been told by the provider that they just want to get paid and that the client needs to help them get paid. This concept of making it financially beneficial for the provider is hurting the clients health and access to health care .

We have had a lot of people auto enrolled into specialty plans that then made them not able to see their doctors. There was no letter sent to the client and suddenly they had a new plan and no doctor. Is there going to be a loophole placed into the MMA that allows the doctor to temporarily bill because of this issue. The client is in the plan for 30 days and cannot change and during this time, it has prevented treatment for HEP C, Cancer and diabetes, and the plans do not seem to care.

I sent this in because I know that we have a limited amount of time.

Thanks

Brandi Geoit

West Coast AIDS Foundation

From: Steven Gale]________________________
Sent: Wednesday, October 26, 2016 10:10 AM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: Managed Medical Statement

Managed Medical Assistance Waiver Extension Comments to Florida AHCA

My name is Steve Gale and I am a pharmacist, actively practicing in Florida for the last 35 years. I have experience in hospital pharmacy retail/community pharmacy, long term care, home infusion/sterile compounding, and for the past 11 years, I've been working in Specialty Pharmacy. I am most concerned that under the current waiver, Medicaid Managed Care plans have been granted the ability to limit participating pharmacies to a very narrow network of retail and mail service pharmacies and if granted an extension this would continue despite the problems it has caused.

Medicaid recipients, due to their inherent lack of financial resources, have demonstrated challenges with maintaining access to basics that many of us take for granted, like reliable transportation, telephone service, and continuous home addresses. Having a computer with internet access is out of the question for most.

Limited access to pharmacies for both acute care prescriptions and maintenance prescriptions for chronic conditions creates unnecessary hardships for many Medicaid recipients and compromises their continuity of care. I attended the AHCA public meeting in Tampa on 10/20/2016 where Beth Kidder presented a 52 page slide deck about the success of the program in reducing PMPM costs. I noticed that there were several slides throughout the presentation that mentioned that one of the major goals of the program was to "Enhance access to primary and preventive care through robust provider networks." How can that access be so important and still justify severely restricting access to pharmacies and pharmaceutical care? I find this to be hypocritical and more of a convenience for managed care plans but a hindrance to access and quality of care for Medicaid recipients.

Limiting the pharmacies that can participate in the retail pharmacy network may cause Medicaid recipients to have to travel outside their local area to fill a prescription or refill a prescription. Some of the problems this model creates include:

- A delay of therapy for new prescriptions at onset of an illness
- Interruption of therapy when refills are too difficult to obtain
- Therapy failures or prolonged illnesses requiring longer courses of treatment
- Poor adherence leading to poor outcomes
- Hospitalizations that could have been avoided

These all translate into increased costs of care that add up to more than can be saved by a restricted pharmacy network.

Required use of mail service pharmacy may have the same effect as limited retail networks. When Medicaid recipients are not able to maintain stable phone service or home addresses, mail service pharmacies have difficulty contacting them and shipping medication to them despite

having sophisticated telecommunication systems to send refill reminders. As a professional in senior management in Specialty/Mail Service Pharmacy for many years, it served my employer well to contract with managed care plans as an exclusive provider of Specialty Pharmacy or to be included in a very narrow network. One of my former (Florida based) employers contracted to be the exclusive Specialty Pharmacy provider for Vermont Medicaid for 2 years. As Director of Pharmacy Operations, I worked very closely with both state officials and the executive management of their pharmacy benefit administration vendor, and I was very involved in monitoring the day to day issues and finding solutions when possible. Although I think my company did the best job that could have been done for this population, I witnessed first-hand many patients who had issues with maintaining stable housing and phone access, and the service issues resulted too often in therapy interruption or failure and all the downstream consequences that ultimately increase the overall cost of care. Regardless of my current employer's interests, as a responsible professional and member of the community I strongly recommend that pharmacy access needs to be as "robust" a network as any other type of provider.

In addition to access, quality of care may also be compromised by utilizing a narrow network despite the consistency that lawmakers believe is a result. Local pharmacies are able to establish relationships with local prescribers and their patients or caregivers who are Medicaid recipients. This makes it more likely for patients to be adherent and participate in a care management environment that fosters collaboration between local providers. The local pharmacist is more likely to be approached by a patient for questions about medication therapy and side effects and trigger an intervention with the prescriber or patient that results in an improved outcome. At the mail service pharmacy, the patient speaks with a customer service rep whose focus is to get the delivery scheduled, then ask the obligatory question, "Do you have any questions for the pharmacist?" so they can check the box to fulfill the regulatory requirement. Patients learn quickly about long hold times and many questions don't get asked.

We need a system where managed care plans do more than focus on reducing unit costs for prescription services and lose sight of the overall cost of healthcare created by limiting access. AHCA and lawmakers may argue that managed care plans manage all the other aspects of healthcare costs, and they certainly try to. But it is also possible that the current model, by limiting access to pharmacy and other services is merely lowering the cost of care by decreasing utilization and ultimately denying necessary care to those most in need. Contrary to what you may believe from my narrative thus far, I do believe in a managed Medicaid system, where competition fosters improved care at lower costs. I just believe that limiting access to pharmacies is not a proper way to achieve the goals. Open networks with participating pharmacy contracts that address both price and quality with meaningful ways to measure quality is the direction I believe we should be moving. The Managed Medicaid health plans need to be accountable for cost, quality and *access*.

From: Brian Lewis [
Sent: Tuesday, November 1, 2016 12:12 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: 1115 MMA Waiver Extension Request ----- completed patient surveys

completed patient surveys explaining how much trouble the managed care medicaid has been and how Staywell in region 2 has affected patients by blocking customers from any pharmacy they choose!

From: Lauren Henderson
Sent: Tuesday, November 1, 2016 11:13 AM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: Public Comments for MMA Waiver Extension Request Meeting

Good Morning,

Below are comments that I was asked to send in from a local pharmacist in Sneads, FL for the Public Comments Period for the MMA Waiver Extension Request Meeting:

1. The patients that are being affected are indigent and need the most help. These are the patients that my stores help the most. From explaining their medications to them one on one to delivering their prescriptions to their front door, we have always taken better care of them than the chains can. We are simply more accessible to these patients and take the time to help them. I would hope at the end of the day that AHCA would want whats best for the patient. Most of my stores are in small towns and these patients are not able to go somewhere else. They don't want to and they don't have the means to travel to a different store.

2. I have heard that AHCA says there is a cost savings in what they are doing. I don't believe it and would have to see it in writing to understand how they feel this way. I know for a fact our stores are cheaper to shop at than the chains. I would invite AHCA and any of the Representatives or Senators from Florida to visit our stores to see what we offer. I think it would be a must for them to do this before making the decision to lock an Independent Drugstore out of their network. I have never understood how a state run plan could lock out a store that pays big taxes in that state. Ridiculous!

3. Last, but not least I would like AHCA to understand what my stores have done with Star Ratings and EQUIPP scores in the last 2 years. These are a way to grade stores on how well they are doing. My stores are striving each day to be in the Top 20 percent of all the stores in the country. We make calls to our patients on a daily basis to remind them of their prescription refills. We do complete medication reviews for our patients to help them understand what each of their medications is for. We do flu shots for these patients in our stores. Quite simply, we do everything we can to keep these patients well and out of the hospital. Bottom line--- we save the health plans a lot of money. Once again, I am extending an open invitation to AHCA and any Representative or Senator to visit one of my stores to see what we do. I will personally give them the tour.

Please let me know if you need any information further.

Thank you,

Lauren Henderson

-----Original Message-----
From: Christopher Muir
Sent: Wednesday, November 2, 2016 6:44 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: 1115 MMA Waiver Extension Request

To Whom It May Concern:

My name is Christopher Muir a pharmacist at the Independent pharmacy Paxon Prescription Center located in Jacksonville, FL. Becoming a pharmacist has been a lifelong dream of mine. It has provided me with the opportunity to help positively change people's lives on a daily basis. Over the years I have been able to build excellent relationships with my patients through trust and outstanding patient care that I pride myself on. Having to tell patients that have filled with us for over 20 years that they may have to leave our pharmacy due to Medicaid Managed Care Health Plans and PBM's restricting their networks is not only heartbreaking for our patients but for me and my staff as well.

Some of these patients that we would be forced to let go are not your ordinary patients. Many of them are heart, lung and liver transplant patients that rely on our delivery service to receive their medications. They rely on our specialty packaging that not only takes the stress out of trying to manage greater than 10 medications on their own but also makes them more compliant to their rigorous medication load.

Paxon Prescription Center also offers a wide range of programs to help assist to our communities healthcare needs including offering immunizations, medication therapy management, patient counseling, blood pressure testing, and a medication SYNC my meds program that has been very successful enrolling over 800 patients.

Our pharmacy also employs 13 people that depend on us to take care of them and their families. We take care of these families not only financially but also provide them with much needed health insurance.
Losing Medicaid would result in many of these employees having to be terminated.

Please change the health care contracts with AHCA to expand network adequacy criteria to include all pharmacies. Many patients well being is at stake as well as many employees that rely on going to work at an independent pharmacy to take care of their families.

Sincerely,
Christopher Muir, PharmD

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GOVERNMENTAL AFFAIRS OFFICE
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850.224.1089 • 800.326.0051
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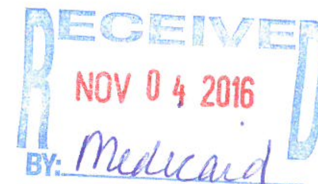

1115 MMA Waiver Extension Request
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

November 2, 2016

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). The Florida Dental Association (FDA) supports the independence of Florida's dental managed care program and dental care being excluded from the scope of services of the MMA.

The FDA's main concern with the MMA is the unnecessary layers of administrative costs that ultimately impact the amount of funds that go to providers who deliver dental care to children in the managed care program. Currently, under the MMA, the MCOs sub-contract dental services from independent dental plans such as MCNA, Argus, Liberty, Dental Health and Wellness and DentaQuest. These sub-contracting arrangements include an additional layer of administrative costs that dilute the funds available to provide dental care. This additional layer of administrative costs does not exist under a separate dental managed care program. An independent dental managed care system works to ensure the limited Medicaid funds available for dental care are focused on patient care, specifically prevention and treatment, and not administrative costs. The MMA integrated care model further depletes 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 $24 billion appropriated by the Florida Legislature for Medicaid services, less than 1% is allocated to the dental program.

Furthermore, there is no provision in the MMA requiring an 85:15 spend ratio on dental by the health plans; however, this medical loss ratio is available in a separate dental managed care program. There is no evidence that the MCO's have maintained this spending ratio at the health plan level and dental plans are receiving less dollars to provide care. This disconnect has trickled down to dental providers in the form of increased administrative burdens and reduced access to care. The FDA believes that under the MMA, a health plan invests considerably less resources in its dental program with no medical loss ratio. Additionally, because there is no transparency for how the money is allocated, it is impossible to ensure that adequate funds are being spent on dental care.

The Agency for Health Care Administration (AHCA) has suggested that the MMA has increased dental coverage for adults as well as children. However, the problem is that the state doesn't pay any more for dental care than the pittance it does now to the plans that offer an enhanced adult dental benefit. How are health plans able to afford this enhanced benefit without an increase in funding? The FDA's assertion is that the plans are spreading the limited funds allocated for children's dental care to also pay for care provided to adults. If the state chooses to offer dental care to adults beyond emergency services, then the state should allocate additional funds for a more comprehensive adult dental benefit. Robbing Baby Peter to pay Adult Paul isn't the way to get there. In addition, there has been no data reported on the amount of adult dental care that has been provided by the plans under the MMA program. Has AHCA requested a report from the health plans to show how many adults are actually receiving dental treatment, beyond emergency extractions and dentures?

AHCA has reported that under the MMA, the HEDIS dental visit score for children is at an all-time high. The FDA agrees that this is a step in the right direction and applauds the efforts by the plans and AHCA to get more children in to see a dentist. However, this score is misleading and still lagging well behind other states. The HEDIS score calculates the percentage of Medicaid eligible children who went in to see a dentist, but it does not report what type of treatment they received or if they even received treatment. Furthermore, during the formation of the State Oral Health Action Plan it was discovered that AHCA and the plans had been underreporting the data on children's dental to the federal government. One of the reasons for the big jump in the HEDIS dental visit score for the past year may have much to do with the more accurate reporting system.

Finally, one of the MMA's goals has been increased transparency. To that end, AHCA has created Health Plan Report cards so that consumers can compare the plans and choose the best one based on quality. However, the rating system is misleading. As explained above, the measure used to grade the MMA plans, the HEDIS annual dental visit score, is not the most accurate way to track actual dental care received by children. In addition, the star rating system is deceptive because it rates the plans based on how the other plans perform and not on achieving a 100% score on the annual dental visit. The ratings key states that for a 5-star rating, which only one plan received, it only needs to rate at or above 50% of all Medicaid health plans' scores. If you look at the one plan that received a 5-star rating, Sunshine Health Child Welfare Specialty Plan, you would see that only 69% percent of its enrollees visited a dentist in the past year. The majority of the plans, the 3 and 4-star plans, had an average of 45% of its enrollees visit a dentist, which, in the FDA's opinion, is not worth a 3 or 4-star rating.

The FDA openly invites a continued discussion with AHCA on the benefits of having an independent dental managed care program. Additionally, the FDA recommends AHCA establish a Dental Care Advisory Council or enhance the Children's Dental Care Subcommittee to help address and ultimately alleviate many of the problems the state is still encountering in the MMA. 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,

C. William D'Aiuto DDS

C. William D'Aiuto, DDS
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

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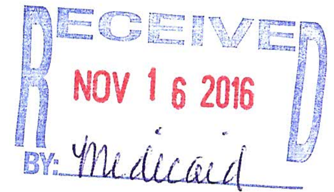
Susan L. Davis, RN, Ed.D.
President and CEO, Sacred Heart Health System, Inc.
Senior Vice President, Ascension Health
Gulf Coast Ministry Market Executive

email: susan.davis2@shhpens.org
www.sacred-heart.org



300759

November 7, 2016

Beth Kidder
Interim Deputy Secretary for Medicaid Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32301

Re: DRAFT Florida's Medicaid 1115 Managed Care Waiver (Project Number 11-W-002064)

Dear Deputy Secretary Kidder:

Sacred Heart Health System appreciates the opportunity to comment on the Agency for Health Care Administration's (AHCA's) 1115 Managed Care Waiver Draft Proposal (Project Number 11-W-002064). Sacred Heart is Northwest Florida's provider of high quality health care to children and adults. Its hub, Sacred Heart Hospital in Pensacola, is the region's only facility specializing in the care of children at the Studer Family Children's Hospital. The Studer Family Children's Hospital is a 117 bed hospital providing a wide variety of services including pediatric oncology, surgery and intensive care and is the only Level III neonatal care unit in NW Florida. Sacred Heart is the largest provider of Medicaid in NW Florida.

Sacred Heart supports the Waiver renewal and moving toward a more efficient, value-driven approach to care delivery. It is a path to modernize the health care system for our low-income patients and stabilize critical hospital financing.

In preparation for the Waiver renewal, FHA established a task force comprised of leaders from hospitals throughout the state, including Sacred Heart, to develop recommendations for consideration. The task force identified three key steps that are integral to its recommendations: redesign how quality health care is delivered, remodel how quality health care is covered, and realign how quality and efficient health care is assured.

Redesigning how care is delivered should begin with reducing inappropriate emergency department visits and preventing avoidable hospital readmissions. These two areas provide the greatest opportunity to improve health outcomes for many Floridians, while significantly reducing costs. We recommend that the Medicaid Waiver proposal include delivery system transformation initiatives that support partnerships between hospitals and community based partners. By utilizing allowable payment innovations in the 1115 Medicaid Waiver, Florida can implement these initiatives without new, State general revenue. Through a very narrow set of provider-led transformation initiatives, hospitals and community-based partners would work to reduce avoidable re-admissions and prevent unnecessary ED visits.

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MD Anderson Cancer Network®
Methodist Homes for the Aging
Nemours Children's Specialty Care

We also agree with the FHA recommendation that AHCA propose sustainable funding sources for Florida's Medicaid program by maximizing existing state resources and restructuring available funding sources. The State should seek Waiver authority from the Centers for Medicare & Medicaid Services (CMS) to secure federal Medicaid matching funds for these existing state and locally funded programs (CMS refers to them as "designated state health programs"). Florida could leverage the considerable funding already provided for low-income individuals to access services such as mental health and substance abuse. CMS has approved the use of Designated State Health Program funding in other states, including, but not limited to, Massachusetts, New York and Oregon.

Remodeling how quality health care is covered is essential to establishing a more efficient, value-driven approach to provide care. Sacred Heart supports the State developing a Florida-specific mechanism to extend health care coverage to low-income, uninsured people. This will provide care to the state's most vulnerable residents, reduce the impact of the uninsured on the State budget and promote timely, appropriate care that is less costly. We believe seeking reauthorization for an uncompensated care pool is the most appropriate request of CMS.

Sacred Heart recommends a strong focus on aligning payments with quality outcomes. This recommendation is based on the concept of value-based payments in which providers are accountable for the care delivered. Key components of this value-driven strategy include increasing operational efficiency, streamlining administrative procedures, increasing the transparency of Florida's managed care program's oversight, preparing providers to participate in value-based payments and establishing new incentives for hospitals, in partnership with community partners, to improve care across the continuum. Sacred Heart has implemented these initiatives already and strongly believes delivery system improvement is possible, beginning with the managed care programs.

Sacred Heart has experienced significant delays in obtaining authorization, or placement, for post-acute care services. This results in patients remaining in the hospital beyond what is medically necessary and is very costly. We support FHA's recommendation that the State include managed care plans subcontractors in each network adequacy review to ensure all subcontractors are able to provide services to multiple plans in a region as proposed.

Sacred Heart is committed to providing high quality of care to all patients, particularly the poor and vulnerable. We are most appreciative of AHCA's proposal to extend the 1115 Waiver, as it will provide health care access to so many of these patients. The 1115 Waiver, in particular, provides the state with the maximum flexibility for improving Florida's Medicaid program through innovations in care delivery and payment reform which we fully support. We look forward to working together to establish meaningful quality improvement and payment reforms outlined here and in the FHA comments.

Again, we thank you for the opportunity to comment on your proposal.

Sincerely,

Susan Davis, Ed.D, RN, FACHE
Ascension Health Market Executive, Gulf Coast
President & CEO, Sacred Heart Health System

MEMORIAL REGIONAL HOSPITAL • JOE DIMAGGIO CHILDREN'S HOSPITA

November 7, 2016

Beth Kidder
Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32301

RE: Draft Florida Managed Medical Assistance Program 3-Year Waiver Extension Request (Project Number 11-W-00206/4) – Comments

Dear Deputy Secretary Kidder:

Thank you for this opportunity to comment on the Agency for Health Care Administration's (AHCA's) draft waiver extension request.

The South Broward Hospital District, also known as Memorial Healthcare System is the local governmental safety net provider for the southern portion of Broward County. We are 6 hospitals with over 1900 beds, a nursing home, home health agency, and many clinics. We employ over 11,000 of the best caregivers and support staff. And we furnish over 215,000 days of inpatient care to Medicaid, the uninsured and underinsured from our community. We have a stake in the outcome, not on behalf of ourselves, but on behalf of the patients and community we serve. We also have a lot of experience with this waiver and access to resources that can help identify and evaluate approaches that would meet the needs of our communities, meet CMS standards, and do so within the limited budget available to the Agency.

Florida's Managed Medical Assistance (MMA) program evolved from the original Medicaid Reform 1115 Waiver approved by CMS in 2005. Multiple extensions of that waiver have enables AHCA to expand the use of managed care state-wide, improve access to specific services, enhance the quality of care, and provide coverage for the uninsured and underinsured for inpatient and outpatient hospital services and a variety of other services.

This extension request proposes to continue the MMA program without any substantive changes, and does not include any continuation of the Low Income Pool. We believe that there are opportunities for AHCA to make improvements in the MMA program, and that it is critical to continue some form of coverage for the uninsured and underinsured whether via a renewal of the

Low Income Pool or another funding mechanism. We provide details of our ideas and concerns in the attached comments. If you have any questions about these comments, please feel free to contact me.

Sincerely,

Scott J. Davis, CPA, CMA, FHFMA
Administrative Director, Reimbursement &
Revenue Integrity
Memorial Healthcare System

Detailed Comments on Florida Managed Medical Assistance Program
3-Year Waiver Extension Request (Project Number 11-W-00206/4)

STATEMENT OF PURPOSE

In this section, ACHA states that it is not proposing any substantive changes in the Managed Medical Assistance (MMA) Waiver. The Agency is also not requesting any waiver or expenditure authorities related to the Low Income Pool (LIP) program.

MMA Waiver Changes

As noted in more detail below, we would propose a number of changes in the MMA waiver that may be deemed substantive. First would be to better coordinate enrollment in the MMA program and the Long-term Care program. Another is to consider extending the inclusion of payments for nursing facility in the MMA capitation rates for all MMA enrollees, not just those under age 18. One more change would be to implement a pass-through payment mechanism to enable plans to improve payments to providers as directed by AHCA. Details on these proposals are below. Our comment here is only that if AHCA agrees with any of these proposals, the wording here will need to alert CMS to those proposed changes.

Low Income Pool

Since the inception of the original Medicaid Reform waiver, CMS has permitted AHCA to make a separate payment to hospitals and other providers for coverage of uninsured and underinsured individuals. Given the limited amount of funding available in LIP, the definition of the covered population and the allocation of funding were also very specific and limited.

For the current 2016-17 State fiscal year, CMS required a new allocation method that incorrectly casts LIP as an "uncompensated care pool." This is not, and has not been the purpose of LIP, as documented repeatedly in the waiver Special Terms and Conditions and other waiver-related documents. While these payments do help defray the financial burden of uncompensated care, the mechanism by which it did so was not a direct measure of uncompensated care – specific programmatic payments were made to promote services of the nature that support uninsured and underinsured patients (primary care, trauma care) or facilities that provide safety net services to this population (teaching hospitals).

This year, the Low Income Pool was capped by CMS at about $607 million. Of that amount, $237 million of State share is being furnished by local governmental entities such as ours, over half just from Memorial, Broward Health and Jackson combined. Of the federal funds generated with these intergovernmental transfers, over $90 million is allocated to hospitals that provide no local match. This level of funding is less than half of the cost of services for uninsured and underinsured patients, does not address the shortfall between Medicaid costs and payments, and forces hospitals to shift costs to other payers in order to keep vital services available.

While CMS has taken issue with the form and format of LIP, we believe there is still opportunity to do a better job of telling Florida's story about the success of LIP in improving access, quality, and health outcomes and reducing cost. Detailed proposals for renewing LIP, and/or replacing LIP with other program(s) are below. Again, our comment here is that some renewal of coverage for Medicaid Eligibility Group (MEG) 3 – LIP is needed, and this section of the waiver extension request will need to alert CMS to that portion a revised request document.

GOALS AND OBJECTIVES

On November 2, 2015, CMS issued a final rule in the *Federal Register* regarding the Medicaid Program; Methods for Assuring Access to Covered Medicaid Services [80 FR 211, 67576-67612, 11/2/15]. In the preamble to this final rule, CMS noted:

"A change in supplemental payments that reduces the total amounts that providers receive or shifts funds from one provider to another could result in access to care issues and is one example of a potential payment restructuring that could negatively impact access to care." [page 67587].

While LIP is not specifically a "supplemental payment program" (i.e., not an additional payment for existing Medicaid enrollees, but rather a new payment for a new Medicaid Eligibility Group), LIP payments are in addition to (and by that meaning "supplemental") fee-for-service and managed care payments.

Consistent with the CMS objectives in this final rule, we would ask that AHCA consider adding to its own objectives:

- Establish payment rates sufficient to ensure beneficiary access to care.

DEMONSTRATION COMPONENTS OF THE PROGRAM

The draft waiver renewal request describes the risk-adjusted premiums component of the MMA program, as well as the implementation of healthy behavior programs. We ask that this section be expanded to include descriptions of the additional MMA improvements and LIP extension/replacement described below.

FEDERAL AND STATE WAIVER AUTHORITY

No comments on this section.

PUBLIC NOTICE PROCESS

No substantive comments. Thank you for the opportunity to present comments at multiple in-person meetings around the State.

HEALTH CARE DELIVERY SYSTEM

ELIGIBILITY

We agree that this waiver extension would not expand Medicaid eligibility beyond what is currently authorized in the State Plan. However, we want to point out that the mechanism of the Low Income Pool – to provide coverage for" the uninsured and underinsured, and establish Medicaid Eligibility Group (MEG) 3 – LIP – has already authorized a group within the State Plan that should continue to be covered, else this extension request would actually be reducing coverage under the State Plan.

ENROLLMENT AND DISENROLLMENT

In addition to the Managed Medical Assistance program, AHCA has also implemented a managed care-based Long-term Care program, with a different set of rules and contracted payors. Our experience with many patients has shown a lack of coordination in enrollment between MMA and LTC plans that frequently causes significant delays in placing patients ready for hospital discharge into a more appropriate, lower cost level of care.

We ask that AHCA consider a modification to the Choice Counseling process to ensure that enrollment in both MMA and LTC programs are accomplished together so that transfer to an appropriate setting is not delayed by a second enrollment process.

BENEFITS AND COST SHARING

Standard Benefit Packages

In this section AHCA points out that Emergency Services are a required covered service. AHCA also notes that plans must ensure that the provision of services is sufficient in amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished.

Recently we have begun to experience an issue with certain MMA plans adopting an automated "prudent layperson" definition of "emergency services" which does not consider the facts and circumstances of individual encounters (such as documented in a medical record), but rather attempts to replace the judgment of the patient presenting for emergency medical services with a code-driven rule set that holds the provider financially responsible for an enrollee's choice to seek emergency care.

This does nothing to discourage the inappropriate over-utilization of emergency room services, as it does nothing to affect enrollee behavior or make appropriate alternative options more available and accessible.

While specific limitations on the types of automated claims review processes permitted is more appropriate in the detailed contracts between AHCA and plans, we believe it would be meaningful to include some statement in this section regarding the definition of "prudent layperson" as meaning the individual seeking emergency services, and not a determination by the plan as to the coverage of such services.

RECIPIENT INFORMATION/ENROLLEE MATERIALS

No comments.

ELIGIBLE PLANS

No comments.

REIMBURSEMENT

The Medicaid reimbursement of plans is described in this document. The reimbursement by plans to providers is the subject of individual payment contracts.

In order to meet CMS's objective of ensuring that payments to providers are adequate to ensure access to services, and to describe more precisely how rates paid to plans, we ask AHCA to include some description of the "actuarially sound premiums" as being based on historical expenditures that are not necessarily limited to Medicaid fee-for-service payment rates.

Such a statement would also be consistent with our request (below) to include a pass-through payment mechanism to enhance or replace the Low Income Pool.

PROVIDER NETWORK AND ACCESS REQUIREMENTS

No comments.

GRIEVANCE AND APPEALS

No comments.

PROGRAM INTEGRITY

No comments.

BUDGET NEUTRALITY

We are pleased to see that AHCA chose to renew the 1115 waiver as opposed to other managed care alternatives and preserve the accumulated $22.8 billion in budget neutrality savings accumulated to date.

FINANCIAL MANAGEMENT STANDARD QUESTIONS

In this section, we ask that the responses to CMS's standard questions be updated to incorporate information related to a renewed Low Income Pool and other payment reforms described below.

QUALITY INITIATIVES

Plan Performance Measures

Our experience with many plans has been that their efforts to reduce over-utilization of emergency room services (or to limit unnecessary inpatient admission or readmissions) has simply been to deny payment to the hospital provider – rather than actually acting to provide coverage in a more appropriate setting for the services that are medically necessary. We recommend an additional Performance Improvement Project to promote plan cooperation in and coordination of alternatives to hospital admissions and readmissions and timely and accessible alternatives to emergency room encounters.

PROGRAM OVERSIGHT

Penalties and Sanctions

[generally describe how penalties and sanctions may influence behavior of plans, but establish the need to make lasting changes. Examples of problems with facilitating transfers, or imposing arbitrary utilization guidelines (prudent layperson for example) or lack of coordination of prior auth for medical and behavioral encounters – Get Sandy's comments]

ADDITIONAL PROGRAMS

No comments.

EVALUATION STATUS AND FINDINGS

Transformation initiatives (described below) are an opportunity for providers to help AHCA redesign how health care services are furnished to achieve better care, better access and better health at a reduced cost. Specific projects, such as reducing medically unnecessary emergency room visits or inpatient readmissions, are tied to very testable hypotheses and trackable data. To

the extent AHCA agrees to incorporate any of the recommended projects below, the section on Proposed Evaluation Activities can be expanded.

WAIVER AND EXPENDITURE AUTHORITIES

In both this section and in Attachment VI, we ask that AHCA change the language regarding the Low Income Pool to request continuation, expansion (consistent with supporting data), and an addition of other projects that may include "costs not otherwise matchable" as a Medicaid expenditure.

SPECIFIC PROJECT RECOMMENDATIONS

Transformation Initiatives

- Inappropriate Emergency Room Visits
- Avoidable Hospital Admissions
- Readmission Reduction

Coverage of Care

- Reauthorization of the Low Income Pool to "provide coverage for" the uninsured and underinsured
- PSN-based, IGT-funded, insurance product for population in ACA coverage gap

Uncompensated Care

- Uncompensated care pool to reduce cost shifting to insured patients

INAPPROPRIATE EMERGENCY ROOM VISITS

An enrollee seeking services in an emergency department that can be reasonably furnished in a physician office or other setting results in a cost of care that is too high in an environment that is already overcrowded. The long wait times after triage, the risk of over-treatment, exposure to a larger volume of sicker patients, and the necessarily rapid pace of emergency room treatment are also things that add to patient dissatisfaction with providers and with the Medicaid program. Projects to more appropriately steer patients to available and accessible alternatives to emergency rooms are much needed.

Provider-led projects have met with some success, but limited. There are some things hospitals can do to make alternative hospital services available (outpatient clinics, urgent care centers), but it is not always economically feasible to make those additional services available geographically as broadly as the distribution of patients seen in the emergency department.

Providers can also coach patients regarding access to these services, even furnish ongoing case management to follow up with patients having chronic conditions resulting in frequent non-emergency visits. But providers have no means to enforce anything with enrollees. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires at least a screening encounter to determine if an emergency medical condition exists. Once it is determined that no emergency exists, a physician will generally treat the non-emergency condition in that same encounter rather than discontinuing care, and referring the patient to another provider. Often, such treatment prevents a non-emergency condition from deteriorating into an emergency one, or recognizes that the patient has no ready access to an alternative provider.

The better solution incorporates the best of what providers have been able to achieve with the projects done already with activities that plans can undertake to help ensure alternatives are available and accessible, and transfers can be timely facilitated. This should also be addressed with benefit changes that, while they do not inappropriately discourage correct emergency room use, provide an added benefit to enrollees who correctly avoid inappropriate use.

AVOIDABLE HOSPITAL ADMISSIONS

CMS has been conducting a project to reduce avoidable hospitalizations for Medicare-Medicaid dual enrollees who are long-stay residents of nursing facilities. Seven organizations (none from Florida) partnered with CMS to develop and implement evidence-based interventions to improve care and lower costs. In Phase Two of this project, CMS is providing additional payment for higher intensity nursing home services for residents who would otherwise be hospitalized. Six medical conditions linked to about 80% of potentially avoidable admissions:

- Pneumonia
- Dehydration
- Congestive Heart Failure
- Urinary Tract Infection
- Skin ulcers/Cellulitis
- Chronic Obstructive Pulmonary Disease/Asthma

Since CMS's project is limited to dual eligible patients, and does not extend yet to Florida, there is an opportunity to extend similar research to a population of individuals who are Medicaid long-term care residents without Medicare benefits.

Funding for the State share of these enhanced nursing home payments could be derived from reduced hospital spending for those admissions prevented.

READMISSION REDUCTION

As required under the Affordable Care Act, CMS's Hospital Readmissions Reduction Program reduces payment to hospitals that experience an excess number of readmissions for certain types of cases. A key assumption in this program is that hospitals are responsible for ensuring both adequate inpatient care to allow an appropriate discharge, and also for post-discharge management of the patient to address any issues that arise which could result in a readmission. Funding for the cost of such additional post-discharge management is not built into the DRG payments hospitals receive, and there is limited payment available under Medicare for "transitional care" services furnished on an outpatient basis.

Similar to the concept of avoidable hospital admissions, an appropriate means of reducing avoidable Medicaid readmissions could be to ensure that there are adequate alternatives to hospital emergency room visits (leading to admissions) or directed readmissions. Rather than

penalties on hospitals for properly treating patients who arrive in the emergency room, incentives for hospitals and plans to work together to coordinate post-discharge services in the appropriate setting can be tested to determine if that is more effective than Medicare penalties in reducing avoidable readmissions.

Funding for the State share of these enhanced nursing home payments could be derived from reduced hospital spending for those readmissions prevented.

REAUTHORIZE THE ORIGINAL LOW INCOME POOL

The latest 1115 waiver renewal by CMS changed the structure of the Low Income Pool in a way that may be consistent with stated CMS objectives, but which demonstrated a lack of understanding of the existing structure of LIP funding and reimbursement.

In its letter to AHCA dated April 14, 2015, CMS stated a number of principles under which it would review an extension of LIP:

- First, coverage rather than uncompensated care pools is the best way to secure affordable access to health care for low-income individuals, and uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion.
- Second, Medicaid payments should support services provided to Medicaid beneficiaries and low-income uninsured individuals.
- Finally, provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care.

The Low Income Pool, as originally designed and applied for Demonstration Years 1 through 9, actually met these principles:

- As defined in the 1115 Waiver Special Terms and Conditions, the Low Income Pool was established to "provide coverage for" the uninsured and underinsured. This category was defined further as Medicaid Eligibility Group 3 – LIP. It defined uninsured and underinsured without specific regard to income, and was therefore even more expansive than expansion under the ACA. That this coverage was limited to hospital inpatient and outpatient services, plus a number of non-hospital projects, was a reflection of the limited funding available combined with the expectation that what payment that was made under LIP be sufficient to promote provider participation and access.
- LIP payments were specifically targeted for services to uninsured and underinsured patients that are necessary and unavoidable (trauma services), efficient and effective in limiting inappropriate emergency room use (primary care services), furnished by providers who operate as the safety net for this population (teaching hospitals), or demonstrate achievement of quality goals. Payments that were made based on the amount of intergovernmental transfers used to fund the State share of LIP were not (as CMS apparently mistook them) "pay to play" payments, but rather a carefully considered

incentive to ensure that those entities with access to resources legally bound to be used to benefit their local populations could share those resources state-wide without reducing the benefits to those local populations.

- While there is still room for improvement, much of the original LIP program IGT funding was used to improve payment rates to those providers who furnished the largest amount of services to the target Medicaid, uninsured and underinsured individuals. These payments significantly reduced the Medicaid shortfall for those years. Currently, State general revenues have been used to replace IGTs as the State share of rates, and therefore (to that extent) would no longer be needed as an IGT-funded rate enhancement.

Since IGTs would not be needed for rate enhancements to the extent previously used, additional funding based on accurate assessments of Florida's uninsured population could be available to expand the types of providers and services covered by LIP.

We do have a concern that CMS withholding LIP authorization for "costs that would be covered in a Medicaid expansion" not only fails to consider LIP as the expansion it was, but also serves as the very type of coercion that the U.S. Supreme Court ruled against. The Florida Legislature has consistently barred Florida's executive branch from implementing any type of Medicaid expansion under the ACA, and for a federal agency to attempt to force State legislative action by withholding funding from a successful demonstration project is not appropriate. Recent political results even indicate that expansion under the ACA may well be undone at the federal level, suggesting that the Florida Legislature's position is an appropriate one.

Given the existing limitations imposed by our Legislature, likely continued federal pressure to reduce or eliminate Medicaid expansion, and the continuing healthcare needs of the uninsured and underinsured population, funding a continued coverage of the uninsured and underinsured via LIP is effective, efficient, and promotes a Florida-specific method for achieving objectives similar to ACA Medicaid expansion.

UNINSURED/UNDERINSURED COVERAGE VIA INSURANCE

Another means of providing coverage for the uninsured could be through a specific insurance product designed to meet the needs of a Florida-specific population and considering the local resources available to fund such a product.

A number of governmental entities in Florida (that is, able to provide IGTs for the State share of expenditures) have formed Provider-Sponsored Networks (PSNs) which have contracts with the State as Medicaid managed care plans. An opportunity exists to use this model to extend coverage to a defined uninsured population, providing the State share of premiums via IGTs.

There are some design elements of such plans that these PSNs may need specific waivers to enable:

1. Narrow network design in their geographic area that does not require the PSN to contract with any specific provider(s).
2. Ability to design benefit packages other than the standard Medicaid benefits that are tailored to the population needs.
3. Beneficiary cost sharing and premiums that are meaningful enough to be useful in managing behavior.
4. Beneficiary cost sharing and premiums that vary by income level.
5. Streamlined enrollment processes that allow continued coverage for some period when other coverage is available.
6. Coordination with other available coverages (e.g., exchange plans), such as limiting PSN enrollment to individuals in the ACA coverage gap (income too high for Medicaid and too low for federal subsidies), such as adults with incomes between 18% and 100% of poverty guidelines.

UNCOMPENSATED CARE POOL

An uncompensated care pool is simply a direct, supplemental payment to providers to defray the cost of services to the uninsured and underinsured so that the Medicaid programs bears a reasonable share of that cost rather than shifting that cost to other insured patients. Assuming that there is first a fair and full assessment of this population and its health care costs, there are multiple methods of implementing and funding such a pool. Distribution can be based on the amount of uncompensated care as a raw number or tiered based on each provider's "ability to bear" those costs.

Managed Care Pass-Through Payments

Federal rules do permit State Medicaid agencies to provide an amount of payment to managed care plans that is specifically directed to identified providers and programs. This opportunity is time-limited and of declining value, but it does currently offer one opportunity to use existing mechanisms to support this coverage.

Designated State Health Programs

Other set of federal rules would allow AHCA to identify certain current State-only programs and modify them to qualify as joint State-federal waiver programs. The additional funds derived via the federal match could be allocated within such waivers to support related uncompensated care costs.

Florida Chapter
American Academy of Pediatrics

November 7, 2016

Justin Senior, Acting Secretary
Florida Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Re: Public Comment on Section 1115 Medicaid Waiver Renewal

Dear Acting Secretary Senior:

The Florida Chapter of the American Academy of Pediatrics (FCAAP) is writing to express our concern about the diminishing access that Florida's Medicaid Children with Special Health Care Needs (CSHCN) have to equal and prompt health and dental care, as required by the Federal Medicaid statute, Title XIX. We are asking that this letter be made a part of the public comments as Florida seeks to renew its Section 1115 Medicaid waiver.

Historically, most of Florida's Medicaid CSHCN receives their care through Children's Medical Services (CMS) within the Florida Department of Health (DOH). There are currently approximately 54,000 Title XIX children in CMS, and approximately 6,000 Title XXI "CHIP" children in CMS. We are writing only about the Medicaid, Title XIX children. Additionally, there are roughly 2,500 Medically Complex Medicaid children in Florida, of whom 2/3, or about 1,600, are enrolled in Florida CMS.

In 2011 Florida passed legislation moving the vast majority of Medicaid children into MMAs. The state legislation required the Federal government's approval in the form of the Section 1115 waiver, but we would note as well that some of these children are receiving Supplemental Security Income, and federal law (Section 438.50 (d)(3)(i)) requires waiver authority before they may be required to enroll in managed care.

As a result, Florida CMS is required to operate as an MMA. The Florida CMS MMA contract is held by the Florida Agency for Health Care Administration (AHCA). That contract restricts Florida CMS to reimbursing physicians who care for CMS patients to payment at the Medicaid level, as established by AHCA and published on the AHCA website. On average, the published Medicaid physician fee schedule is 56% of the Medicare rate for the same geographic area.

In 2005 FCAAP, along with the Florida Academy of Pediatric Dentistry and 9 individual patients, filed suit against Florida Medicaid for failure to assure that Florida's Medicaid Children have equal and prompt access to health and dental care, as required by Title XIX. That suit was

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settled in April of this year. That settlement calls for Florida's MMAs to provide a reasonable opportunity to physicians who see Medicaid children to earn Medicare equivalent reimbursement levels through achieved savings, without an infusion of new dollars into the program. This program is phased in over a three-year period. The initial groups of physicians eligible to earn the increased payments, with some exceptions, are board certified pediatricians who are also certified as a Patient Centered Medical Home (PCMH). (PCMH designation is expensive and complex and is only achievable by the minority of Florida's board certified pediatricians, currently estimated at 20%. The settlement calls for AHCA to extend this opportunity to other physicians as savings permit.) The settlement also calls for Defendants to meet certain metrics demonstrating improved access to medical care within several years, and if defendants do not meet those metrics, which will require Florida Medicaid to meet national norms, AHCA must institute corrective plans that will enable a broad range of physicians participating in MMA plans to earn the Medicare fee-for-service rates, subject to certain incentives and disincentives.

Similarly, the settlement calls for AHCA to meet certain access-to-care metrics demonstrating improved access to dental care. If AHCA does not meet those metrics, which are phased in over a longer period than the metrics for improved access to physicians, then AHCA must implement corrective action plans that will provide dentists participating in Florida Medicaid with a reasonable opportunity to earn increased payment rates at an amount equal to the 50th percentile of commercial dental payments for pediatric dental services furnished in Florida.

The lawsuit settlement did not specifically resolve the problem of how and whether physicians who see Florida CMS children will be eligible for enhanced payments. Instead, the settlement calls for representatives of FCAAP, AHCA and DOH "...to meet and collaborate in good faith on the best methods of servicing the needs of CMS children." (See attached Settlement Agreement, IV. 1., pp. 15-16) Our concern is that Florida CMS, as a non-risk-bearing entity and per the contract with AHCA, has no opportunity to achieve savings to increase payments to those physicians who see Florida CMS Medicaid children. Thus, we have a situation in which physicians, who care for the children covered by Florida CMS, even though those children have a higher illness burden than do average Medicaid children, are not eligible for enhanced payments. On the other hand, when those same physicians see non-CMS, average Medicaid children, some of those physicians are compensated at an enhanced rate, and others should have the opportunity to earn an enhanced rate in the future.

This is creating a serious access problem for children on Florida CMS. Physicians who traditionally cared for these children are, sometimes, able to be reimbursed more to see average Medicaid children, than to see the more complex Florida CMS CSHCN. As a result, fewer and fewer physicians are willing to care for Florida CMS children. This, in turn, is seriously

diminishing the access that Florida CMS children have to equal and prompt access to health and dental care, compared to Florida's average Medicaid children, who are not on Florida CMS.

To resolve this problem, DOH is considering having Florida CMS administered by a third party entity on an at-risk basis. FCAAP does not see this as an acceptable option. Third party entities administering the MMA plans for average Medicaid children have been unable to provide the level of nurse care coordination, social services, and networks of primary care and specialty physicians necessary to assure that children on Florida CMS indeed have equal and prompt access.

Instead, FCAAP proposes that DOH adopt a model that retains the current CMS structure, thereby retaining the nurse care coordination, social services, and primary and specialty physician networks already established in local communities; FCAAP proposes that DOH seek approval from AHCA to use the enhanced payment fee schedule available to the MMAs caring for average Medicaid children to boost payments to those physicians seeing CMS children. It is our understanding that the funds needed may be available by savings within the existing CMS/Medicaid budget; if not, an additional appropriation may be needed. It is our recommendation that AHCA consider a different financial strategy such that CMS children continue to have the same quality standards in a coordinated care delivery system with an emphasis on medical homes.

As you consider the upcoming renewal of Florida's 1115 Medicaid waiver, we petition you to make whatever waiver revisions with Federal CMS and whatever contractual changes between AHCA and Florida CMS, such that the CSHCN insured by Florida CMS truly have equal and prompt access to health and dental care, to the same extent as do average Florida Medicaid children.

Respectfully,

Madeline Joseph, M.D.; FAAP, FACEP
President, Florida Chapter of the American Academy of Pediatrics

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Changing Health Care for Good.®

Michael D. Aubin
Hospital President

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Wolfsonchildrens.org

November 8, 2016

Beth Kidder
Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Re: Florida's Medicaid 1115 Managed Care Waiver

Dear Deputy Secretary Kidder,

As the only full-service tertiary hospital for children in North Florida, Wolfson Children's Hospital is dedicated to providing high-quality, safe health care to the children of our community and beyond. With that commitment in mind, we appreciate the opportunity to provide the following issues for consideration with the request to extend Florida Medicaid's 1115 Managed Medical Assistance Waiver.

Redesign How Health Care is Delivered

The Medicaid Waiver proposal should include delivery system transformation initiatives that focus on addressing improving care transitions. Through a set of transformation initiatives, hospitals can work to reduce avoidable re-admissions and prevent unnecessary ED visits. Children's Hospitals focus on addressing care of chronic and complex patients through care coordination. These initiatives would focus on improving care transitions, addressing complex patients with high social needs, and strengthening community-based care. Wolfson Children's Hospital recommends expanded access to primary care physicians through broad based increase in payments to primary care practices. Despite the outcome of the recent settlement, it is estimated that less than 50% of pediatricians will benefit from the decision.

Remodel How Quality Health Care is Covered

Remodeling how quality health care is covered is essential to establishing a more efficient, value-driven approach to provide care. Wolfson Children's Hospital believes it is imperative that the state of Florida develop a Florida-specific mechanism to expand healthcare coverage to low income, uninsured people, including the 280,000 estimated uninsured children.

Even with additional coverage, Florida will continue to have high number of transient workers and immigrants who do not qualify for coverage. CMS has allowed the continuation of uncompensated care pools in those

states as acknowledgment of this fact. Wolfson Children's Hospital believes the state should seek the reauthorization for Florida's uncompensated care pool, referred to as the Low Income Pool, as it ensures access to care for our state's uninsured residents. Florida's uncompensated care pool should be consistent with CMS's payment principles and sized appropriately given the state's level of uncompensated care and the low amount of Disproportional Share Hospital funding.

Realign How Quality Health Care is Assured

With the opportunity to improve care and lower costs through the waiver renewal, Wolfson Children's recommends including pediatric standards of care in quality metrics. With almost all of Florida's Medicaid beneficiaries enrolled in managed care, there are opportunities to improve delivery systems, including network adequacy requirements. Wolfson Children's Hospital believes pediatric subspecialists should be included in networks to prevent children from having to leave their area because of contract agreements. We suggest creating a provision to prevent Medicaid managed care companies from dropping essential providers such as a tertiary Children's hospital and disrupting the care of thousands of children and forcing them to drive many hours for essential services. In addition, there is a need to provide appropriate access to pediatric home health services for these medically complex children. Wolfson Children' s Hospital has patients that continue to live in our intensive care units because of lack of alternative and more appropriate facilities. In addition, we have experienced significant delays in obtaining authorization for post-acute care services. Currently, there is lack of focus on the pediatric population, as approximately 4% of the Medicaid population is medically complex, and results in nearly 50% of expenditures.

As Wolfson Children's Hospital is committed to providing quality health care, we appreciate AHCA's proposal to extend the 1115 Waiver. Thank you for your consideration of these opportunities to improve the health of children.

Sincerely,

Michael D. Aubin, FACHE
Hospital President

c: Vikki Wachino
Deidre Gifford
Representative Cord Bryd
Representative Travis Cummings
Representative Tracie Davis
Representative Kimberly Daniels
Representative Jason Fisher
Representative Jay Fant
Representative Paul Renner
Representative Clay Yarborough
Representative Cyndi Stevenson
Senator Aaron Bean
Senator Rob Bradley
Senator Audrey Gibson
Senator Travis Hutson
Senator Keith Perry
Representative Elizabeth Porter
Representative Bobby Payne

November 8, 2016

Mr. Justin Senior
Secretary
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

RE: Medicaid's 1115 Managed Medical Assistance (MMA) Waiver - Comments on a three-year extension and the imperative to continue the low income pool (LIP) program.

Dear Mr. Senior:

The Florida Association of Children's Hospitals (FACH) urges state lawmakers and health officials to request continuation of Medicaid funding for hospital charity care in fiscal year 2017-18 through the Low Income Pool program. This supplemental funding is critical to helping children's hospitals offset the costs of providing quality care to Florida's sickest, most vulnerable children. Without this extension, the state will lose an estimated $608 million needed to provide life-saving hospital care to all residents and our children, regardless of their ability to pay.

While the federal government may wish to phase out the Low Income Pool program, FACH believes the state needs to aggressively seek continuation of the LIP program and additional charity care replacement funding from Washington to make up for recent reductions. In the past two years, Florida has seen its LIP funding slashed dramatically, from $2.2 billion in 2014-15 to $608 million in 2016-17.

The LIP is the only program through which hospitals may receive assistance for providing charity care to Florida's poor and uninsured. Florida hospitals continue to provide over $1 billion in uncompensated charity care to uninsured Floridians which is particularly critical for the children of our State.

Texas and California both have large LIP-like federal funding programs. As the nation's third largest state in population, Florida should fight for its fair share of federal Medicaid funding and demand that LIP be maintained. Without federal support of the costs of hospital care to the uninsured, Florida's hospitals treating large numbers of poor, uninsured patients will be forced to shift those unreimbursed costs to paying patients.

We respectfully ask state leaders to work with the Centers for Medicare & Medicaid Services (CMS) in coming up with solutions to ensure the future viability of children's hospitals and the families and children they serve.

FACH is comprised of 16 member hospitals throughout the state whose mission is to: share and disseminate knowledge, information, experiences, and research. FACH encourages the development of the most effective means of delivering comprehensive healthcare and access to the children of Florida.

Attached is a fact sheet regarding FACH.

Thank you for your consideration of these comments.

Sincerely,

Jerry A. Bridgham, MD
President

Attachment

From: allison biszantz
Sent: Tuesday, November 8, 2016 10:48 AM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: 1115 MMA Waiver Extension Request...but I'm a consumer who writes for Herald, see link

My name is Allison Biszantz

I used to wish I qualified for Medicaid. Now, I shudder to think about what that would mean in terms of pharmacy limitations and closed pharmacy networks. If it's up to me, I'll never patronize a chain pharmacy again. They make me feel like a number, not a person.

My health profile is unique to me and complicated.

I have bipolar disorder, tardive dyskinesia from the bipolar meds, binge eating disorder from the bipolar meds, prediabetic from the bipolar meds, chronic pain, psoriasis....I had a terrible experience with Publix Pharmacy....and interviewed 3 independants and made my choice. Aloe Drug Mart. I have to drive j20 miles each way but they are the very best. Ade, the owner and his staff treat me, the whole Allison, rather than script by script. They warn me of drug interactions and side effects but never judge.

Here are two links to stories I wrote about independents becoming an endangered species in Florida and let me know what I can do to help.

Miami Herald and Bipolar Hope, a national online community and magazine.

I got an email from Ade this morning about an opening to make a statement but it seemed to be more for pharmacists, not consumers.
Allison Biszantz
Herald 'System Rigged'
http://www.miamiherald.com/opinion/letters-to-the-editor/article107271937.html
Bphope "Pharma Back" Facebook

https://www.facebook.com/bpMagazine/posts/1559325687426286

From: Christian Nwoye
Sent: Tuesday, November 8, 2016 11:54 AM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Cc: ugaland1@aol.com
Subject: PUBLIC COMMENT FROM A CONCERNED CITIZEN, TAX PAYER AND A PROUD BUSINESS OWNER, EMPLOYER

Sir/Madam,

My heart aches and wrenches when I see the way law makers, the executive branch and even the judiciary of the State of Florida through ill conceived policies, regulations and irreverent tactics as employed cheat the state of millions, if not billions of dollars in business deals, dealings and other unnecessary aggrandizing behaviors and moves. I am sick and tired of being taken advantage of and so are other millions of Floridians who are either indisposed or incapable of defending themselves. I have decided as a private citizen, a tax payer and a business owner, employer use this medium to ask the entire class of individuals involved in the state public policies and fiscal decision handling to quit these addictive habits in order to save our state from undue corrupt influences killing our public institutions.

Politics is about policies that are fair and equitable. Politics is a public service no individual is forced to enter into and therefore those who go into public service for their career paths are hereby advised to manage themselves professionally to help the state move in the right direction. From my lamentations and appeals, entreaties above, it is good that I tell you why I was absolutely so inclined to generate those outbursts without any reservations, that the truth be told to shame the devil and his hand workers:

1. restrictive MMA policy is an arbitrary abuse of power that employs intimidating, high-handedness restricting highly qualified individuals from giving their age-long professional services to the state citizens by restricting consumer access to their veritable inputs accumulated over their professional practice and exposure.

2. AHCA MMA is a quack practice promoter by replacing highly qualified, experienced individuals with new kids on the block practitioner kiddies working for deep pocket, crying baby corporations like Walgreens, CVS, Wal-Mart that now found themselves incapable of competing with confident independent practitioners. Personally as an individual, I came out of the pharmacy school in June 1987, licensed since September immediately after. That is a 354-month long practice experience that customers disallowed to come to my business are not accessing. How does my experience compare with those at Walgreens, CVS or Wal Mart populated with these kids, most of them who just came out of school? Is that really an honest deal you are giving to the Florida consumers the MMA restrictive network approach deny a choice?

3. Demonstratively, an unintended consequence is that MMA restriction of network participation is a job killer and therefore an unemployment creator. That is because small employers like me will loose his or her business, lay off his or her workers, creating unemployment lines for the state.

4. Listening to the AHCA Director say during the recently concluding in-door meeting at the AHCA office in Tampa, Hillsborough county area 6 zone that no patient could be forced to stay with a network sounded like an off the wall statement because I remember my experience with

Katherine Green, Richard Peterson and others I cannot remember now and I can tell you that these two individual were forced out of my pharmacies after all their efforts making calls, and being directed here and there that they gave up. I am in contact with them and they will come for any testimony if called up to do so, they assured me.

I will like to end my observations so far here and wait to see what direction things go because I know this fight is not ending today, soon.

Thanks and as always

Christian NwoyeB.PharmR.Ph

President & CEO
Ugaland Inc d/b/a City Pharmacy
3302 E. Dr. Martin L. King Blvd
Tampa, Florida 33610
813-248-5405
813-248-5408 (Fax)

From: VP PHARMACY
Sent: Tuesday, November 8, 2016 11:56 AM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: 1115 MMA Waiver Extension Request

We support our patients' right to choose the best available option for their pharmacy services.

After Working both for a retail pharmacy, CVS, for 10+ years and now for an independent pharmacy, I can honestly say that at the independent pharmacy level we are able to go above and beyond for our patients. We are part of the community and help with many community health fairs, patient education services with Diabetes and Hypertension, offer free delivery, and assist with taking patients to their doctors visits, and much more.

Patronage of independent pharmacies, such as ours, helps to supports the local economy with personalized patient care not found at most chain pharmacies.

Please consider Florida's residents first over Big Business. Thank you.

Nandram Persad, Owner of VP Pharmacy

VP PHARMACY
7617 N. 56TH STREET
TAMPA, FL 33617
PH: 813-988-0818 FAX: 813-988-0830

From: Kevin Duane
Sent: Tuesday, November 8, 2016 5:57 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: 1115 MMA Waiver Extension Request

Please end the practice of these private companies restricting our Florida Medicaid recipients from freedom of choice in pharmacy services. It is totally unfair that recipients are forced into these narrow networks and forced away from pharmacies that they choose to use. In addition, small business owners are now being left out of participation in medicaid networks that their tax dollars go to fund! This is very detrimental to the patients, and to the small business pharmacy owners of Florida. Thank you.

Kevin J Duane, PharmD
Panama Pharmacy
Jacksonville, Florida
(904)-765-3531

From: osteensrx
Sent: Wednesday, November 9, 2016 1:04 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: "1115 MMA Waiver Extension Request"

I am writing today as I was not able to attend one of the gatherings held throughout the state. My name Greg Toole and I am a pharmacist and pharmacy owner in Jacksonville,Fl. My pharmacy, Osteens Pharmacy, has been serving patients in our area since 1954. I am very concerned about the restrictive networks that have shut out my pharmacy from several of the medicaid managed care plans/PBMs. This raises concerns on many different levels. First and foremost I am concerned for my patients who have a relationship, which I see as being very important, with my pharmacist and staff. No one likes change, especially when it is forced on them, and 100% of my patients feel this way. We are truly different when it comes to patient care. We provide our patients with free delivery service, special packaging, and an adherence program designed to improve health outcomes, and do this at no additional charge for the patient or managed care plan. I find it interesting that visiting nurses for the Molina program often refer patients to our pharmacy that would benefit from our packaging product, and this one of the programs we will no longer be able to accept. This sounds like the PBM really doesn't care about patient care. On another level as a tax payer in the state of Florida, I feel like all pharmacies should be allowed to participate if they desire too. State funded programs should be open to all just like the original medicaid program is open for all. Lastly, we are a small business in the state and employee between 13 and 16 people. We provide health insurance, 401K benefits, excellent work environment and excellent pay for our employees. If we are restricted from participating in the programs, we will loose twenty percent of our business. This will lead to a loss of jobs. I know our Gov. Rick Scott has worked hard to create jobs in our state and would not want to see any of my employees on the unemployment rolls.

Sincerely

Greg Toole RPh.
Paxon prescription Center,Inc dba
O'steens Pharmacy
757 N. Edgewood Ave
Jacksonville, fl 32254
904-388-0514

From: Bill Mincy
Sent: Wednesday, November 9, 2016 4:08 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: Comments to Deputy Secretary Beth Kidder Regarding Florida Medicaid Waiver and Closed Pharmacy Networks
Importance: High

Deputy Secretary for Medicaid Kidder,

Thank you for conducting the recent public meetings in Tallahassee, Tampa and Miami regarding AHCA's 115 MMA Waiver Extension Request. I appreciated your presentation and willingness to listen to the concerns and suggestions of Florida small business pharmacies who want to serve the needs of Florida's MMA recipients.

In addition to my comments provided at the Tampa meeting I have attached additional comments for AHCA 's consideration regarding the 1115 MMA Waiver Extension Request on behalf of Pharmacy Choice & Access Now (PCAN), PPSC, the Florida Independent Pharmacy Network (FIPN) and more than 1,300 Florida small business pharmacies that we represent. A copy of the attachment was also mailed to your offices.

Please feel free to contact me by phone or email if you have any questions or need additional clarification. I am available to meet with you and your staff in Tallahassee when convenient to further discuss the challenges and remedies associated with closed pharmacy networks operated by Florida's MMA health plans.

Respectfully yours,
Bill Mincy, BPharm
National Board Chairman,
Pharmacy Choice & Access Now

VP Business Development and Government Affairs,
PPSC LLC, USA
3375-I Capital Circle NE | Tallahassee, FL 32308
Phone: (850) 553-3595 | Fax: (850) 895-3052
www.ppsconline.com| Like PPSC on Facebook!

From: Super Discount
Sent: Wednesday, November 9, 2016 5:06 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: "1115 MMA Waiver Extension Request"

Hi,

I have been an independent pharmacy owner for almost 10 years. We have been serving our community with a lot of passion and dedication. Lately our business has been severely compacted by the restrictive Medicaid Managed Care Health plan networks. We can no longer service a lot of our patients and this has caused a lot of anxiety and delay in care of these patients. A great number of patients only speak Spanish and are having real difficulties in finding a network pharmacy that has a bilingual staff at all times. Our pharmacy employs bilingual staff at all operating hours.

Our pharmacy has also suffered financially due to these restrictions and we may have to cut staff. We cannot understand the rationale behind the restrictive networks. Our pharmacy services Medicare Part D and Part B patients and currently have a high star rating across all measures required by CMS.

We humbly request to be included in all Medicaid Managed Care Health plans to avoid these touch situations for our customers.

Thank you

Manjit Matharu
Manager
Super Discount Pharmacy,
Plant City, FL 33563.
Tel: (813) 752-1133
Fax: (813) 752-8866

1115 MMA Waiver Extension Request

To Whom It May Concern,
This is in response to your request for input from providers regarding your seeking federal authorization to extend Florida's Managed Medical Assistance (MMA) Waiver for the period of July 1, 2017 to June 30/ 2020. Below are issues that we pediatric occupational therapists, physical therapists and speech therapists have been experiencing since the initiation of the MMA:

1.Many providers have difficulty being contracted with MMA plans.
2.Plans report a full network of therapy providers but often those therapists listed are no longer contracted, are more than 50 miles away or only work with the adult population.

3.Many children cannot receive treatment due to problems with transportation particularly when the therapist is many miles from their home. I believe 50 is the allowable. This is a tremendous financial and time consuming burden on the families
4. Several providers have reported being terminated by a plan if the plan knew that the provider had complained to AHCA about issues and difficulties with that plan .
5. Often therapy services are not approved at a level that would be consistent with the amount, duration and scope that were available through the Medicaid Fee for Service Program (Medipass). Often the therapy is approved at levels that are not sufficient to achieve the goals established in the Plan of Care.
Frequently the denial is based on criteria that is felt to be more restrictive than criteria for service authorization and is not following the EPSDT guidelines. T**he MMAs have 'guidelines' they have adopted to help them determine how much care a child gets and they ignore the EPSDT guidelines of looking at the individual. Please read the following EPSDT guidelines.**

Because medical necessity decisions are individualized, *flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements*.[42] States may adopt a definition of medical necessity that places t*entative limits* on services *pending an individualized determination by the state, or that limits a treating provider's discretion*, as a utilization control, but additional services must be provided if determined to be medically necessary for an individual child.[43] For example, while a state may place in its State Plan a limit of a certain number of physical therapy visits per year for individuals age 21 and older, such a "hard" limit could not be applied to children. A state could impose a "soft" limit of a certain number of physical therapy visits annually for children, but if it were to be determined in an individual child's case, upon review, that additional physical therapy services were medically necessary to correct or ameliorate a diagnosed condition, those services would have to be covered.

6. Often access to therapy services is not in a timely manner because authorizations can be delayed up to 15 days.
7. Because of the reduction in reimbursement rates and complex, time consuming authorization processes many therapist are closing their practices.
8. Some of the MMA plans subcontract with third party utilization companies that capitate payment, reducing reimbursement and therefore forcing the provider to reduce treatment. The provider is legally obligated, per the contract, to provide whatever the patient needs, but that places providers in an ethical bind since it is usually financially not feasible to do so.
9. Some MMA's have had or currently have issues with providing multiple therapies (occupational and speech therapy) on the same day based on guidelines established for Medicare for rehabilitation settings. In addition, some MMA's have instituted payment reductions based on the multiple procedure reduction guidelines from Medicaid even after the state indicated that the rule did not apply to Medicaid. As a result, Some MMA plans did not pay for any OT, but this has been rectified for some settings. In another case, the insurance companies consistently pay less for the second service-despite any rule governing this.
10. MMA credentialing is very inefficient. In one case, a therapist was to be credentialed by an MMA plan. Two years later, when she was finally added to the roster she had since left the practice.

11.Some plans timely filing deadlines are only 90 days which often is not sufficient time to resolve issues and the provider again is not reimbursed.
12. Although there is a complaint system in place for the providers to inform AHCA of MMA issues , it is unsatisfactory since frequently the representatives consider the problem solved when the agency contacts the plan. AHCA has relied on the MMA plan to resolve the problems and does not provide any guidance or oversight into how the problems is resolved. There is no follow up, requiring numerous time consuming calls to the plan by the provider and frequently with no resolution. Resolution to problems have tended to apply only to the provider(s) that submit complaints even when the problem has been systemic. AHCA does not develop rules or guidance letters that are applied to correct systemic problems so that MMA plans change the way in which they are operating improprerly.
I appreciate the opportunity to have our issues heard. I hope that these can be resolved.

Sincerely,
Enid Gildar, MA,CCC-SLP (Chairperson for the Florida Speech Language and Hearing Association Medicaid Task Force): Alain Lopez, Ph.D, CCC-SLP; Charlene Westman, MA,CCC-SLP; Deborah Campbell,MA.CCC-SLP; Meme Smith, MS,CCC-SLP; Jan Wooten MS,OT; Stephanie SpinelliOT, OT; Ami Tishkoff, MA,CCC_SLP; Robert Fifer, Ph.D, AuD,CCC-A; Richard J. McLoy, MS,CCC-SLP/L; Stephanie Spinelli, MS,OT;,Millie Suarez,MS,CCC-SLP; Alliete R. Alfono, MS,CCC-SLP; Felicie Abby, MS,CCC-SLP;

From: ALOE DRUG MART
Sent: Wednesday, November 9, 2016 9:37 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: 1115 MMA Waiver Extension Request

To whom it may concern,

I am a Pharmacy owner in Florida who owns a small business, provides employment in Florida and serves my Floridian patients. As a citizen of and an employer in Florida, I am emailing you today to urge AHCA to develop new Florida Medicaid Managed Care Contracts. We need to change the Health Plan MCO contracts to mandate EVERY Florida pharmacy is included.

We as small business owners work hard every single day and night to support our families and our communities, these managed care claim they are excluding independent Pharmacies and business owners under the guise of " Star Measures and Wellness" . My Pharmacy has a 4.5 star rating under the Medicare program and private HMO that we're contracted with. These are information available on Medicare websites and public information for that matter. One would ask how come we're not even contacted about these contracts? Most of this patients that we have serviced for years even receives letters about our Pharmacies being kicked out of contracts before we get to know.

Below is the patient's personal story regarding this policy in the Miami Herald on the 9th of October 2016:

"State Medicaid system 'rigged'

While we ponder our choices (or lack of) awaiting open enrollment, an assault on the American Dream is being waged against small pharmacies in Florida.
"Work hard, play by the rules and prosper" is a nightmare for our independent, or indie, pharmacists. The playing field has never been level, but now these stand-alones are largely out of network in privatized Medicaid plans. They're required to pay Medicaid taxes but can't fill Medicaid prescriptions. This is troubling.

Indies offer a plethora of goods and services large chains can't, don't or just won't. Indies meet your eyes when you arrive. They know your health profile like the back of their hand. They fill hundreds of prescriptions a day, as opposed to thousands. For the housebound, they'll home deliver. There's on-site compounding, diabetic supplies, free health magazines, etc. Whatever you need they'll order. That's the point, to treat the whole patient, not just fill a prescription.
Gov. Rick Scott's privatization of Medicaid was supposed to be about free enterprise. That's just a guise.
Here's an example of why I need my indie: When he caught wind of a price hike on one of my prescriptions, he stocked up, and gave me a 90-day heads up. Can you imagine that happening with an hourly worker at a supermarket chain?

Behemoths have their benefits, like being open 24/7. That's not helpful if you're really sick, live hours away or don't drive. They have databases, but a computer won't pick up on the pallor or sudden weight loss of a patient. For that, you need a human being.
Corporate outfits claim lower prices negotiated by their powerful Pharmacy Benefit Managers (PBM), who claim to be part of the solution. But the top three PBM's have three-quarters of the market share. They profit from every transaction and also can own drugstore chains. This gives them incentive to drive patients toward their stores by any means possible. It's the American way, right?
Not in this case. We need to outlaw closed pharmacy networks and insist on fair play for the corner mom-and-pop shop. Small businesses drive our economy.

Allison , Hollywood"

I thank you for your time and your service in representing the people of Florida. Please help Florida patients get connected to real pharmacists and give them the right to choose where they eceive their prescriptions and pharmacy services.

BY HAND & EMAIL TO FLMedicaidWaivers@ahca.myflorida.com

November 9, 2016

Interim Deputy Secretary Beth Kidder
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, FL 32308

Re: 1115 MMA Waiver Extension Request

ViiV Healthcare Company (ViiV) appreciates the opportunity to submit comments to the Florida Agency for Health Care Administration (Agency) regarding its 1115 Managed Medicaid Assistance (MMA) Waiver extension application. ViiV is an independent, global specialist HIV company established in 2009, committed to delivering innovative new options for the care and treatment of people living with HIV/AIDS. From day one, we have been dedicated to the treatment of HIV, allowing us to address the significant gaps and unmet needs in the HIV space. ViiV's employees are committed to addressing the needs of people living with HIV around the world.

In addition to developing innovative treatments for people living with HIV, ViiV also advocates for increased access to those treatments in order to save lives and to help reduce the transmission of HIV. Accordingly, we support the development of non-discriminatory insurance benefit designs and the elimination of HIV disease screening and treatment barriers in public and private programs. ViiV also works with various healthcare stakeholders across the continuum to promote the adoption of relevant HIV quality measures that will further ensure clinically supported and appropriate patient care.

Scientific advances in the prevention and treatment of the virus have played a significant role in transforming HIV/AIDS from an unavoidable death sentence to a manageable chronic disease. Public investments and collaboration among advocates, providers, and community based organizations have also played a key role in these advances as well as increased access to treatment. Medicaid, the largest public health insurance program in the United States, covering health and long-term care services for more than 72 million low-income individuals, has played a critical role in HIV care since the HIV epidemic began.[i] It is the single largest source of coverage for people with HIV in the U.S. and the number of Medicaid beneficiaries with HIV has grown over time.[ii]

ViiV applauds the Agency's efforts to seek innovative methods to expand eligibility, increase the quality of care, and reduce costs in its MMA program through its 1115 waiver. Specifically, we support the Agency's goals to: (1) improve access to coordinated care; (2) promote an integrated health care delivery system that provides incentives for quality and efficiency; (3) enhance access to primary and preventative care through robust provider networks; and (4) improve program performance, particularly improved scores on nationally recognized quality measures.

To build upon the successes gained over the past three years, ViiV recommends the following additions to Florida's 1115 MMA waiver extension application:

(1) Require insurance plans to use Florida's Medicaid State Plan preferred drug list (PDL) and prohibit the use of additional utilization management tools beyond those already used by the State.

(2) Include HIV quality measures in the annual Managed Medicaid Assistance Health Plan Report Card.

Require insurance plans to use Florida's Medicaid State Plan PDL and prohibit the use of additional utilization management tools beyond those already used by the State

As you know, insurance plans participating in the first three years of the MMA program were required to implement the state's PDL in the first year. This meant that plans could not add utilization tools that are more restrictive than what is already used in the state's Medicaid program. Utilization management tools can potentially cause delays in access to needed treatments, which in turn, may negatively affect a patient's overall health. When used inappropriately, utilization management tools may also be used to discriminate against patients with certain chronic conditions that require more costly medicines. Utilization management tools have particularly impacted people living with HIV and AIDS, who rely on uninterrupted access to innovative medicines to manage a chronic but deadly disease. Greater access to insurance coverage has the potential to improve continuous access to care and treatment for people with HIV, which can positively impact individual health outcomes and reduce the risk of HIV transmission.[iii] [iv] While utilization management tools can sometimes be effective in cutting costs, they can also be burdensome and time consuming and have a significant impact on people living with HIV and AIDS.

Requiring plans in the MMA program to continue to use Florida's PDL would ensure that plans do not use utilization tools inappropriately; clarifies for providers that regardless of the MMA plan, all their Medicaid patients have similar access to the same formulary; and provides consistency for patients who benefit from continued adherence to prescribed treatments. We recommend that the contracts with the MMA plans include a requirement that they follow Florida's PDL and prohibit utilization management that is more restrictive than what the State has implemented.

Include HIV quality measures in the annual MMA Health Plan Report Card

ViiV commends Florida and the Agency for adopting quality measures to improve performance and drive value based care in its MMA program. The trends of linking quality to the value of care and using quality information to inform patient choices will continue to grow as they are critically important to assuring that health care reforms preserve and enhance patient outcomes. While ViiV does not create quality measures, we have a committed interest in ensuring the robustness of quality that supports better care for individuals and improved overall population health within publically supported and market-based health care programs.

ViiV supports the implementation of quality measures that meet the following characteristics:

- Endorsed by multi-stakeholder, evidence-based quality organizations, such as the National Quality Forum (NQF);
- Reflect higher performance in helping to achieve patient-centered outcomes;
- Based on evidence-based processes; and
- Aligned across multiple care settings and providers to harmonize the use of measures in various reporting programs to help reduce reporting burden and accelerate improvement.

HIV quality measures are critical to the care and treatment of people living with HIV. Approximately 1.2 million people are infected with HIV, and one in seven (14 percent) are unaware that they are infected. Despite groundbreaking treatments that have slowed the progression and burden of the disease, the pace of new infections continues at a high level, especially among certain demographic groups including Blacks/African Americans and Hispanics/Latinos.[v] Implementing the HIV viral load suppression quality measure would support public health priorities, such as reduced viral load, and the use of HIV Antiretroviral Therapy has been linked

with improved overall health, quality of life, and decreased risk of HIV transmission.[vi] [vii] [viii] ViiV appreciates Florida's implementation of HIV quality measures in its current MMA program as well as the transparency of the annual Health Plan Report Card. However, the MMA program does not specifically include these measures in the report card in a clear manner. Including these and other measures in the report card would not only improve the strength of the report card tool, but also enhance the state's ability to fully realize quality measures and assess the value of care.

Thank you for your consideration and the ability to participate in Florida's 1115 MMA waiver application process. ViiV looks forward to working with the State, the Agency and other stakeholders to ensure that Florida's public programs continue to ensure patients have access to quality care and to improve health outcomes. Please feel free to contact me at (919) 323-9084 or Cindy.C.Snyder@viivhealthcare.com should you have any questions.

Sincerely,

Cindy Snyder

Cindy Snyder
Community Government Relations Director
ViiV Healthcare

cc: Justin Senior, Interim Secretary, Agency for Health Care Administration

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[i] CMS. Medicaid & CHIP: March 2016 Monthly Applications, Eligibility Determinations and Enrollment Report. May 25, 2016 https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/march-2016-enrollment-report.pdf
[ii] Kaiser Family Foundation. State Health Facts. Medicaid Enrollment and Spending on HIV/AIDS. (FY07-FY11). http://kff.org/health-reform/stateindicator-enrollment-spending-on-hiv
[iii] Heather Bradley, et al. Centers for Disease Control and Prevention. "Vital Signs: HIV Diagnosis, Care, and Treatment Among Persons Living with HIV — United States, 2011." *Morbidity and Mortality Weekly Report*.63(47);1113-1117. November 28, 2014.
[iv] Myron S. Cohen, et al. "Prevention of HIV-1 Infection with Early Antiretroviral Therapy." *New England Journal of Medicine*. 365(2011):493-505.
[v] Center for Disease Control and Prevention, HIV in the United States: *At A Glance*, http://www.cdc.gov/hiv/statistics/basics/ataglance.html
[vi] D. Donnell, et al., *Heterosexual HIV-1 Transmission After Initiation of Antiretroviral Therapy: A Prospective Cohort Analysis*, 375 The Lancet 2092, 2095 (Jun. 2010)
[vii] Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, NIH, http://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf
[viii] World Heath Organization (WHO). Adherence to long term therapies—evidence for action. 2003. http://www.who.int/chp/knowledge/publications/adherence_full_report.pdf

November 9, 2016

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 Beth Kidder and team:

My name is Bill Mincy and I am sending this letter to you on behalf of Pharmacy Choice & Access Now (PCAN), PPSC, a pharmacy services firm based in Tallahassee that works with the Florida Independent Pharmacy Network (FIPN) and more than 1,300 small business pharmacies operating today in Florida. These pharmacies employ close to 13,000 Floridians and generate almost $5 billion in annual sales, providing vital jobs and substantial tax revenues to the State of Florida.

These organizations and the pharmacies we represent want to coordinate with the Agency for Healthcare Administration (AHCA) and help them achieve their Medicaid Managed Care (MMC) plan goals and initiatives including:

- Improve recipient access to coordinated care
- Promote an integrated health care delivery model that incentivizes quality and efficiency
- Enhance performance and access to preventative and primary care through robust provider networks
- Improve program performance and HEDIS quality measures scores
- Improve health outcomes through care coordination and recipient engagement in their own health care
- Enhance fiscal predictability and financial management
- Increased transparency and accountability.

We are especially supportive of AHCA's goals to provide robust provider networks and increase the transparency and accountability of the MMC Program. We recommend AHCA extend its provider network, transparency and accountability efforts to address and stop the exclusionary pharmacy provider contracting practices of MMC health plans and their pharmacy benefit managers (PBMs).

The situation we find ourselves in today is that upstanding, tax paying Florida community pharmacies are experiencing significant provider network closures by MMC health plans despite their credentials, CMS Five Star quality measures and willingness to accept the health plans terms and conditions extended to closed network participating pharmacies.

This means more than 3 million Floridians could be forced to leave their community pharmacist and go to a different pharmacy or mail order firm chosen by their MMC health plan rather than what's best for the patient or their family members.

In many cases, these patients have very unique circumstances which require additional pharmacist attention and specialized pharmaceutical care that enables them to take care of their families and lead productive lives. However instead of focusing on their illnesses and treatment plans these folks are forced to deal with the frustrations, delays, transportation challenges and other access problems created by MMC health plans and PBMs for their own financial gain.

For example, in a recent The Wall Street Journal article dated Wednesday, November 9, 2016, the author writes about how CVS Health regularly takes advantage of contractual relationships with healthcare payers to benefit themselves. The article states "*By owning Caremark (CVS' PBM) as well as thousands of drugstores, CVS Health has been able to closely align both businesses to encourage patients to fill prescriptions somewhere within the CVS empire*." The article is attached with this letter.

We strongly recommend Florida community pharmacies be allowed to qualify and participate in MMC health plan pharmacy networks based on their individual credentials, CMS Five Star quality measures and willingness to accept the plans terms and conditions in order to care for and help their most vulnerable patients.

If the health plans that AHCA accepts for MMC plans would allow patient choice and access to their pharmacy, the State of Florida would be in a position where patient care would not be at risk, outcomes are improved and AHCA's cost containment goals and initiatives are achieved.

On behalf of PCAN, PPSC, FIPN and the more than 1,300 small business pharmacies in Florida, I respectfully request that AHCA take action now to stop exclusionary pharmacy networks and modify its 1115 Waiver Request to require MMC health plans to operate open pharmacy networks that benefit Medicaid patients, AHCA, and all of Florida's citizens.

Sincerely,

Bill Mincy

National Chair
Pharmacy Choice and Access Now

Vice President Government Affairs
PPSC

gsk do more feel better live longer

November 9, 2016

Interim Deputy Secretary Beth Kidder
Office of the Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, FL 32308

Hand delivered and submitted by email to FLMedicaidWaivers@ahca.myflorida.com

Re: 1115 MMA Waiver Extension Request

GlaxoSmithKline (GSK) appreciates the opportunity to submit comments to the Florida Agency for Health Care Administration regarding its application to the Centers for Medicare and Medicaid Services (CMS) to extend the state's 1115 Managed Medicaid Assistance Waiver.

GSK applauds the Agency for Health Care Administration's efforts to seek innovative methods to expand eligibility, increase the quality of care, and reduce costs in its Medicaid program through its 1115 waiver. Specifically, we support the Agency's goals to:

- Improve access to coordinated care;
- Promote an integrated health care delivery system that incentivizes quality and efficiency;
- Enhance access to primary and preventative care through robust provider networks; and
- Improve program performance, particularly improved scores on nationally recognized quality measures.

GSK is a science-led global health care company that researches and develops a broad range of innovative medicines and brands to help patients do more, feel better, and live longer. While GSK does not create quality measures, we have a committed interest in ensuring the robustness of quality that supports better care for individuals and improved overall population health within publically supported and market-based health care programs. The trends of linking quality to the value of care and using quality information to inform patient choices will continue to grow as they are critically important to assuring that health care reforms preserve and enhance patient outcomes

A well-constructed quality strategy is of vital importance to achieving the goals outlined in Florida's MMA program. To that end, GSK supports the implementation of quality measures that meet the following characteristics:

- Endorsed by multi-stakeholder, evidence-based quality organizations, such as the National Quality Forum (NQF);
- Reflect higher performance in helping to achieve patient-centered outcomes;
- Based on evidence-based processes; and
- Aligned across multiple care settings and providers to harmonize the use of measures in various reporting programs to help reduce reporting burden and accelerate improvement.

GSK comments Florida for the adoption of quality measures to improve overall health as a part of its initial 115 Medicaid waiver request, and supports the inclusion of the following quality measures in the waiver extension application:

Immunization Quality Measures

During the 20th century, the life span of Americans has increased by more than 30 years in part because of the use of vaccines, and mortality from infectious diseases in the U.S. has been reduced 14-fold through the use of vaccines, according to the U.S. Department of Health and Human Services.[i] The preventive nature of vaccines helps to improve patient outcomes and curtails treatment costs on the healthcare system. The Florida Department of Health's Immunization Program has made great strides in increasing adult vaccination rates between 2012 and 2016 as evidenced by the "Immunization Coverage Award" recognition in 2016. Adopting adult immunization quality measures is the natural next step to build upon this achievement.

do more
feel better
live longer

GSK recommends the following measures that support immunizations for routine use in adults and that have a recommendation from the Advisory Committee on Immunization Practices (ACIP).

- NQF #0041: Influenza Immunization (Clinician, Health System, Health Plan)
- NQF #0431: Influenza Vaccination Coverage among Healthcare Workers (Health System)
- NQF #0043: Pneumococcal Vaccination Status for Older Adults (Clinician, Health System, Health Plan)

GSK notes that despite ACIP recommendations and Healthy People 2020 targets, adult immunization rates remain low.[ii] Quality measures have the potential to increase immunization rates.[iii] Adult immunization quality measures currently focus on influenza and pneumococcal immunization. GSK supports the development of quality measures that increase adult immunization rates for ACIP recommended vaccines.

COPD Quality Measures

Chronic obstructive pulmonary disease (COPD) is the third leading cause of death in the U.S. and causes serious, long-term disability.[iv] As of 2011, 15 million Americans have been diagnosed with COPD; of this total, approximately 50% were not aware their lung function was not at full capacity, a primary symptom of COPD.[v] [vi] Therefore the number of Americans with COPD may actually be greater than 15 million, indicating an under diagnosis of COPD exists.[vii]

A recent study conducted by the Centers for Disease Control and Prevention (CDC) shows the significant economic and quality of life impact that COPD is taking on the U.S. The research found that:

- In 2010, total national medical costs attributable to COPD were estimated at $32.1 billion and total absenteeism costs were $3.9 billion for a total burden of COPD-attributable costs of $36 billion.
- An estimated 16.4 million days of work were lost because of COPD.
- Of the medical costs, 18% was paid for by private insurance, 51% by Medicare, and 25% by Medicaid.
- National medical costs are projected to increase from $32.1 billion in 2010 to $49.0 billion in 2020.[viii]

More than 1.1 million Floridians are diagnosed with COPD.[ix] In fact, Florida has the highest total medical costs in the U.S. for COPD, totaling $2.5 billion per year, and also has the ninth highest rate of COPD in the country.[x]

GSK considers COPD disease management a significant component for better patient outcomes and lower long-term costs. GSK supports the inclusion of the following COPD measures as they focus on diagnosis and adequate treatment and exacerbation control and may possibly help impact quality of life and healthcare costs.

- NQF #0028: Tobacco Use Assessment and Tobacco Cessation Intervention (Clinician)
- NQF #0091: COPD: Spirometry Evaluation (Clinician)
- NQF #0577: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (Health System, Health Plan)
- NQF #0102: COPD: Inhaled Bronchodilator Therapy (Clinician)
- Former NQF #0549: Pharmacotherapy Management of COPD Exacerbation (Clinician, Health System, Health Plan, Population)
- NQF #0275: PQI 05: COPD or Asthma in Older Adults Admission Rate (Population)
- NQF #1891: Hospital 30 Day All Cause Risk-Standardized Readmission Rate following COPD Hospitalization (Health System)
- NQF #1893: Hospital 30 Day All Cause Risk-Standardized Mortality Rate following COPD Hospitalization (Health System)

Care Coordination/Medication Management

Care coordination involves organizing activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care, according to the *Agency for Healthcare Research and Quality (AHRQ)*. Care coordination is identified by the Institute of Medicine (IOM) as a key strategy that could help improve the effectiveness, safety, and efficiency of the U.S. healthcare system.[xi]

An important part of care coordination is medication management. Proper use of medications can lead to improved health, enhanced quality of life, and increased productivity. Therefore, GSK supports medication management measures as well as the development and implementation of measures for Comprehensive Medication Management (CMM), a continuous, systematic process used by providers to ensure patients' medications are coordinated, appropriate, and understood by the patient.

GSK supports implementation of the following measures because they help encourage coordination between various aspects of an episode of care, including patient transitions between providers and from provider care to home health and post-acute care, which are the times that are prone to medical misadventures due to lack of coordination and interconnectedness between agencies.

- Pharmacy Quality Alliance (PQA) Measure: Medication Therapy Management (MTM) - Proportion of MTM-eligible members who received a Comprehensive Medication Review (CMR) (Clinician, Health Plan)
- NQF #0097: Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility (Clinician)
- NQF #0419: Documentation of Current Medication in the Medical Record (Clinician, Population)
- NQF #0553: Care for Older Adults – Medication Review (Health System, Health Plan)
- NQF #0554: Medication Reconciliation Post-Discharge (Health System, Health Plan)
- NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (Health System)

Thank you for your consideration and the ability to participate in Florida's 1115 MMA waiver application process. GSK looks forward to working with the state and other stakeholders to ensure that Florida's public programs continue to ensure patients have access to quality care and to improve health outcomes. Please feel free to contact me at (270) 791-6564 or Christopher.J.Bryce@gsk.com should you have any questions.

Sincerely,

Chris Bryce
Government Relations Account Director
GlaxoSmithKline

cc: Justin Senior, Interim Secretary, Agency for Health Care Administration

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[i] The State of the National Vaccine Plan, 2013 Annual Report
[ii] MMWR, February 7, 2014/ 63(05); 95-10
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[iv] Heron M. Deaths: Leading Causes for 2010. *National Vital Statistics Reports.* 2013;62(6)
[v] The Morbidity & Mortality: Chart Book on Cardiovascular, Lung, and Blood Diseases. The National Heart, Lung, and Blood Institute; 2012. Accessed on July 1, 2013.
[vi] Mannino DM, Gagnon RC, Petty TL, Lydick E. Obstructive lung disease and low lung function in adults in the United States: data from the National Health and Nutrition Examination Survey 1988-1994. *Arch Intern Med.* 2000;160:1683-1689.
[vii] Centers for Disease Control and Prevention, "Chronic Obstructive Pulmonary Disease (COPD)." (2013 April 25). http://www.cdc.gov/copd/
[viii] Total and state-specific medical and absenteeism costs of chronic obstructive pulmonary disease among adults aged ≥18 years in the United States for 2010 and projections through 2020, Earl S. Ford, MD, MPH; Louise B. Murphy, PhD; Olga Khavjou, MA; Wayne H. Giles, MD, MS; James B. Holt, PhD; Janet B. Croft, PhD, *Chest.* 2014. doi:10.1378/chest.14-0972
[ix] CDC Behavioral Risk Factor Surveillance Survey (BRFSS) for 2014.
[x] CDC Behavioral Risk Factor Surveillance Survey (BRFSS) for 2014.
[xi] Care Coordination, The Agency for Healthcare Research and Quality, http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/

2985 Drew St.
Clearwater, FL 33759

November 9, 2016

Beth Kidder
Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

Submitted via email to FLMedicaidWaivers@ahca.myflorida.com

Dear Ms. Kidder,

Thank you for the opportunity to submit comments concerning the proposed extension of Florida's 1115 MMA Waiver. BayCare is a leading not-for-profit health care system that connects individuals and families to a wide range of services at 14 hospitals and hundreds of other convenient locations throughout the Tampa Bay and central Florida regions. Our mission is to improve the health of all we serve through community-owned, health care services that set the standard for high-quality, compassionate care.

I would like to focus our comments on four main areas:

Extension of Medicaid supplemental funding:

In transitioning to a managed care system for providing Medicaid, the existing Low Income Pool funding system was jeopardized. By including the continuation of the Low Income Pool in the last waiver, AHCA ensured a continuous and sustainable funding pool to help offset some of the expense that hospitals bear to treat Florida's sickest and most vulnerable citizens. From its peak of $2.1 billion to the current level of $608 million, the Low Income Pool ensured that that Medicaid funds would go to those providers that disproportionately met the demand for Medicaid services within our state.

We strongly encourage AHCA to amend its waiver proposal to include a renewal of the Low Income Pool at least at its currently funded level. While CMS has reduced the total value of the Low Income Pool over the last two years, the reduction was based at least in part on the basis that "uncompensated care pool funding should not pay for costs that would be covered in a Medicaid expansion." Based on CMS's own math, there remains an unmet level of uncompensated care of at least $608 million even if Florida were to expand Medicaid.

Moreover, other states such as Texas and California have received large uncompensated care pools similar to LIP.

The hospitals within BayCare provide a significant level of charity care in our community. The Low Income Pool methodology used this state fiscal year reinforced this contention as we had six hospitals within BayCare merited in the top three tiers, half of which were in the top tier. Ensuring continued supplemental funding, be it through an extended Low Income Pool program or a new methodology, is vital to the continued financial health of the state's Medicaid system.

Ensuring access to quality care for Medicaid enrollees:

By its nature, the Florida Medicaid program serves many of the most vulnerable within our population. Children, pregnant mothers, and the disabled make up the vast majority of Medicaid enrollees. There are three areas specifically where access to care for Medicaid enrollees can be improved.

- Finding skilled nursing facilities willing to take Medicaid eligible ventilator patients is a major challenge for our hospital case managers. The few that took patients have largely stopped and what access remains is largely focused on short-term, weanable vent patients. We encourage AHCA to consider payment and policy reforms that will incentivize skilled nursing facilities in Florida to accept ventilator patients.

- St. Joseph's Children's Hospital has partnered with Children's Medical Services to help improve care management for CMS-enrolled children with chronic and complex medical conditions in Tampa. CMS is to be lauded for finding an innovative solution to improve the quality of care their enrollees receive. Unfortunately, one out of six children that had been enrolled in the CMS specialty plan have been dis-enrolled since the summer of 2015. While CMS has made important efforts to reform the enrollment process, there are still thousands of children that had been part of a pediatric-focused specialty network and are now part of a more general Medicaid plan. We would ask AHCA to put in place protections to ensure that the plans that have absorbed Medicaid-eligible children with complex medical needs to have the provider networks necessary to treat those kids.

Ensuring transparency with the MMA program:

Even before the legislature acted this past year, Florida Health Finder included a voluminous amount of data reported by hospitals and ambulatory surgical centers in a publicly available format. The public could access what types of patients a given hospital sees by age, gender, principal diagnosis, and payer. Unfortunately, there is little similar data for the plans that are part of the MMA program.

We encourage AHCA to publicly provide information that would help the public better understand how the plans are managing utilization over time. This could include the following by plan:

- Utilization of hospital ER and inpatient services per 1000 enrollees on a risk adjusted basis.

- Risk-adjusted hospital readmission rates.
- Ratio of non-emergent to emergent emergency room use per 1000 enrollees on a risk adjusted basis.
- Information showing the denial rate for prior authorization requests.
- Percent of prior authorization requests are resolved within 7 days.
- Percent of expedited authorization requests are resolved within 3 days.
- Reporting on claim denial rates.

Paving the way for innovative delivery system reform:

Across health care, providers are working to reform and improve the way we provide care to our patients. We courage AHCA to consider how the MMA program can be updated with new delivery system reforms to ensure that any savings wrought by the system accrue to the benefit of Medicaid enrollees in the form of better health. These could include financially sustainable patient-centered medical homes, incentives for providers to provide greater care management, and requirements for plans to develop programs to effectively manage the health of their enrollees.

The Florida Hospital Association has proposed a Payment Reform and Delivery System Transformation Initiative that would focus on strengthening community-based care, improving care transitions, increasing access to mental health and substance abuse services, and addressing complex patients with high social needs. We courage AHCA to consider how the FHA plan could be incorporated into the waiver.

Thank you again for the opportunity to provide comments on the proposed extension of the 1115 waiver. Should you have any questions, please do not hesitate to reach out to Clint Shouppe at 727-519-1885.

Sincerely,

Carl Tremonti
Chief Financial Officer – Hospital Division
BayCare Health System

November 10, 2016

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

Re: 1115 MMA Waiver Extension Request

Dear Sir or Madam:

VITAS Healthcare® would like to offer the following comments as part of the State's pursuit of federal authority to extend Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 to June 30, 2020. Improvements to this Waiver should reinforce access to the Medicaid Hospice Benefit as it was intended to deliver high-quality end-of-life care to the terminally-ill and mirror that intent in its reimbursement of the service. The next Waiver must standardize care delivery and reimbursement for Hospices and Medicaid Managed Care Organizations (MMCOs) by following the universally accepted industry standards of the federal Hospice Conditions of Participation, Agency for Healthcare Administration Regulations and Florida State Law for determining Hospice appropriateness and levels of care. Since the inception of Florida's first 1115 Managed Medical Assistance Waiver, MMCOs have developed altered authorization and billing requirements that have no basis for treating and covering the needs of the terminally-ill.

I. Background on VITAS

VITAS Healthcare® was founded in Miami Florida in 1978 as Hospice Care, Inc., one of the nation's first Hospice programs and serves patients through its comprehensive range of Hospice programs in 15 States and the District of Columbia. For over 30 years, **VITAS** has been a leader in the American Hospice movement, helping to define the standards of care for Hospice and working to ensure that terminally ill patients and their families have ready access to compassionate and effective end-of-life care through Medicare and Medicaid. On average, VITAS serves more than 16,000 patients each day and employs approximately 11,700 people. More than 90% of VITAS' patients receive care in their own homes**.**

As a Hospice pioneer, **VITAS** was instrumental in leading a bi-partisan effort to add cost effective Hospice care to the health care payment system. As a result of these efforts, Medicare pays for Hospice services, many States have established Medicaid coverage for Hospice, and virtually all private insurers and managed care plans provide coverage for Hospice care. VITAS also actively participated in shaping Hospice policy: a VITAS representative served during 1994-1995 on the Hospice Wage Index Negotiated Rulemaking Committee that developed the current Hospice wage index methodology, including the Budget Neutrality Adjustment Factor (BNAF).

Today, **VITAS** is the leading provider of cost effective end-of-life care in Florida and across the country, working in cooperation with hospitals, physicians, nursing homes, assisted living facilities, insurers and community-based organizations in Florida and throughout the nation. Thus, *VITAS has an informed historical and practical perspective on the development of Florida's pursuit to extend its 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) for the period July 1, 2017 to June 30, 2020.*

II. Background on the Medicaid Hospice Benefit

Hospice services have been a covered benefit under Part A of Medicare since 1983. The Medicare Hospice Benefit proved to be so advantageous from both a quality and cost perspective that in 1985 states were given the option to provide the Medicaid Hospice Benefit that all states except Oklahoma have since adopted. To qualify for Hospice benefits, a beneficiary must have a life expectancy of 6 months or less, assuming the illness runs its normal course (as certified by a physician), and must voluntarily elect Hospice. Once a beneficiary elects Hospice, the beneficiary foregoes all curative treatment for the terminal illness and related conditions (though curative treatment is covered for unrelated conditions), and in return is eligible to receive a variety of palliative care services, including some not normally available under regular Medicare and Medicaid benefits.

The Hospice Benefit includes an array of services furnished to terminally ill individuals. These services include: case management nursing, medical social services, physician services, counseling services to the terminally ill individual and the family members or others caring for the individual at home, short-term inpatient care, medical appliances and supplies, home health aide and homemaker services, physical therapy, occupational therapy and speech-language pathology services.

Individuals must elect the Hospice Benefit by filing an election Statement with a particular Hospice. They must acknowledge that they understand that other Medicaid services for the cure or treatment of the terminal condition are waived. Additionally, a Hospice Provider must obtain a physician certification that an individual is terminally ill and Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. A Hospice plan of care must be established before services are provided and updated throughout the patient's length of stay.

The Medicaid Hospice Payment Rates are authorized by section *1814(i)(1)(C)(ii)* of the Social Security Act (the Act), which also provides for an annual update in payment rates for Hospice care services. Medicare and Medicaid Hospice services are paid for on the basis of four per diem rates, with each rate determined by the level of service based on patient need and whether it is provided at home or inpatient basis. With the exception of payment for physician services Medicaid reimbursement for Hospice care is made at predetermined rates for each day the individual receives care under one of the following levels of Hospice care:

1. *Routine Home Care*, (RHC), Hospice Providers are paid one of two levels of (RHC). This two-rate payment methodology results in a higher RHC rate based on payment for days one (1) through sixty (60) of Hospice care and a lower RHC rate for days sixty one (61) or later.

2. *Continuous Home Care*, (CHC), is furnished during a period of crisis and primarily consists of nursing care.
3. *Inpatient Respite Care*, (IRC), is short-term care and intended to relieve family members or others caring for the individual.
4. *General Inpatient Care*, (GIC), is short term and intended for pain control or acute or chronic symptom management which cannot be provided in other settings.
5. Effective January 1, 2016, *Service Intensity Add-On* provides that Hospice Services are eligible for an end-of life service intensity add on payment when the following criteria are met:
    a. The day on which the services are provided is an RHC level of care;
    b. The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased;
    c. The service is provided by a registered nurse or social worker that day for at least fifteen minutes and up to four hours total and
    d. *d.* The service is not provided by the social worker via telephone.

III. **Authorization Challenges**

MMCOs have demonstrated limited knowledge of the Medicaid Hospice Benefit and an inability to properly cover the service for members. In Florida, there are twenty three independently operated MMCOs; each with their own unique and arduous requirements for authorizing the Medicaid Hospice Benefit. Despite Federal Conditions of Participation for certifying and recertifying terminally-ill patients, MMCOs require additional documentation and prior authorizations for reimbursement.

Complicating matters, Hospice Providers must inquire with each MMCO to determine specific authorization processes for each plans' beneficiaries. Typically, MMCO authorization process changes are not communicated to Hospice Providers prospectively; resulting in significant rework and denials for Hospices to absorb. Furthermore, the majority of MMCOs have not expanded their online portals to include Medicaid Hospice products. As a result, Hospice Providers cannot check benefits or obtain authorizations through these portals or Electronic Data Exchange (EDI) and obtaining documentation specific to Hospice billing is unavailable.

The administrative cost for Hospice providers to comply with unnecessary, duplicitous and significant authorization requirements is burdensome and has resulted in an increase of administrative staffing costs.

IV. **Delayed Reimbursement Due to MMCO Administrative Burdens**

The Medicare Hospice Benefit is the predominate source of reimbursement for Hospice Services. According to the National Hospice and Palliative Care Organization (NHPCO), Medicare covers 85.5% of Hospice patients versus other payment sources and 90.3% of patient days versus other sources in 2014. Conversely, NHPCO states that Medicaid programs cover 5% of Hospice patients and 4.3% of patient days. It has been challenging for the Hospice Industry to adapt to this sizable shift in payer mix for the Medicaid patient population. In fact, VITAS has substantially increased it administrative support staff to meet the increased demands and burdens of participating in the Florida Medicaid Managed Care program.

MMCOs have developed unique billing requirements that differ from Florida Medicaid. Obtaining documentation specific to Hospice billing requirements are often unavailable. Additionally some MMCOs are not able to accept electronic claims submissions; typically increasing Accounts Receivables for paper claims 60 more days. MMCOs are often out of compliance with Florida State Statues as it relates to the processing healthcare claims, requiring high volumes of appeals and the initiation of grievances. VITAS has incurred increased legal and consulting costs to circumnavigate incorrect and delayed reimbursement.

MMCOs have had difficulty in correctly configuring their claims processing systems to correctly accept and adjudicate Hospice claims. The number of incorrect denials and time to correct claims processing systems is not compliant with the Florida State Statutes for prompt payment. Often times, exorbitant efforts must be taken by Hospice Providers to escalate errors through internal and external grievance process, resolution and subsequent reimbursement taking years to achieve.

VITAS proposes that MMCOs applying for contracts to administer a Managed Medicaid Hospice product participate and pass a claims testing process with Hospice Providers to validate their systems' capabilities. MMCOs that cannot correctly configure their claims processing systems to accept and adjudicate Hospice Claims should be mandated to comply or not be awarded a Medicaid Managed Care contract.

Lastly, MMCOs must maintain compliance with Medicaid and Medicare reimbursement guidelines. The majority of MMCOs have not implemented the two-tiered routine home care reimbursement methodology or the additional Service Intensity Add-On despite the federally required by the January 1, 2016 effective date and State law 409.982(5) and 409.983(7).

V. Higher Levels of Care Limitations

The subsequent Florida Medicaid Waiver must reinforce the high quality and entire scope of services provided to terminally-ill patients by the Medicare and Medicaid Hospice Benefits. Changes to the Hospice authorization process has created barriers to care, in particular higher levels of care that are considered emergent. It has become standard for MMCOs to require additional documentation to approve authorizations for higher levels of care, despite Hospice Provider adherence to CMS criteria for General Inpatient Care (GIC) and Continuous Home Care (CHC) appropriateness and documentation.

The additional requirements to obtain authorizations for GIC and CHC have become exponentially rigorous. Terminally-ill patients in crisis cannot wait for MMCO approvals that can take days or weeks for the MMCOs to generate. Hospice providers risk reimbursement by providing this care without timely prior MMCO authorization.

The next State Waiver must prohibit plans from denying higher levels of care GIC and CHC to ensure terminally-ill beneficiaries in crisis receive the high acuity pain control and symptom management they need.

VI. **Physician Visits**

Although the Hospice benefit is well defined in the Florida Medicaid fee schedule, MMCOs are limiting the benefit through contractual negotiations and undue authorization requirements. Physician visits are a key component of the Hospice continuum of care. The nature of Hospice physician visits are not conducive to a prior authorization process, practically given the retrospective coding of visit types. According to VITAS National Medical Director Dr. Joseph Shega, the preponderance of patients on Hospice remain homebound and are only able to visit with a physician outside their residence. In conjunction with the rest of the interdisciplinary team, physician visits facilitate pain and symptom management needs, streamline medication use, the discontinuation of inappropriate therapies, better delineate goals of care consistent with patient values and beliefs, and improve satisfaction scores. As a result, Medicare and Medicaid programs reimburse physician visits outside of the per diem to encourage greater physician engagement. Physician visits also provide value in reducing hospital readmissions and as a result should be reinforced in Florida's next 1115 Waiver contract.

VII. **Hospice Nursing Home Room and Board Pass Through**

As Medicaid Managed Care has been expanded to include dual-eligible residents in nursing homes, there is confusion as to whether the Memorandum of Understanding between Florida Medicaid and CMS provides an exemption to the Social Security Act §1902(a) (13) (B). This law specifies that the reimbursement rate paid for "room and board" is required to be at least 95% of the rate that would have been paid by the State under the plan for facility services in that facility for that individual.

Some MMCOs in Florida are seeking to benefit from the 5% savings, but are unwilling to administer the Hospice Nursing Home Room and Board Pass Through in compliance with the federal law. Specifically, some health plans are offering Hospices a "blended" or flat Hospice Nursing Home Room and Board Pass Through payment rate regardless of the nursing home's actual room and board rate. This blended rate appears to conflict with federal law regarding the 95% room and board pass through payments for Hospice patients in the nursing home.

MMCOs in Florida are requiring authorizations for Hospice Nursing Home Room and Board Pass Through reimbursement, complicating a process outlined in the Social Security Act that is simply an administrative function of a Beneficiary's decision to utilize their Long Term Care benefits.

Additionally, MMCOs are not factoring in beneficiary's "Patient Liability" when reimbursing Hospice Room and Board Pass Through, resulting in substantial overpayments. Beneficiary liability is based on income status as determined by Florida's Medicaid program. As a result of these incorrect overpayments, an inordinate effort is made by VITAS to return these funds to the MMCOs, adding to the administrative cost of participating in the Medicaid program. To date, VITAS is dealing with multiple MMCOs that do not recognize a Patient Liability component to the Hospice Nursing Home Room and Board Pass Through reimbursement.

In our extensive experience, most MMCO do not understand the concept of the Hospice Room and Board Pass Through. Therefore, VITAS recommends that MMCOs engage a physician with Hospice or palliative care experience to assist in the design and implementation of MMCO Hospice products. The Act is cited for reference:

> *Social Security Act § 1902(a) (13) (B)*
> *(B) for payment for Hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of Hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive Hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual;*

VIII. **Recommendations**

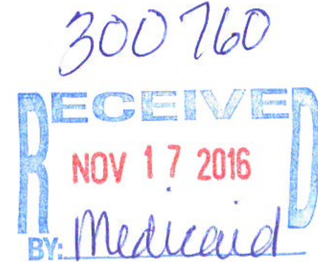
VITAS appreciates the opportunity to submit these comments and looks forward to working with federal officials, the Agency for Healthcare Administration, and MMCOs to ensure that all Florida Medicaid beneficiaries and their families continue to have access to high quality end-of-life care that Hospice services provide.

Given the challenges outlined above, it would be extremely beneficial to all affected stakeholders if Florida's 1115 Managed Medical Assistance (MMA) Waiver (Project Number 11-W-00206/4) clarifies and standardizes the above mentioned issues. We welcome an opportunity to answer questions or discuss these issues with you further. My phone number is (513) 618-2240 and my e-mail address is nick.westfall@vitas.com.

Sincerely,

Nick Westfall
EVP, Chief Executive Officer of VITAS Healthcare

3901 E. Colonial Drive
Orlando, FL 32803-5245
PH: 407-898-4427 • FX: 407-897-2108



November 10, 2016

Beth Kidder and Staff
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

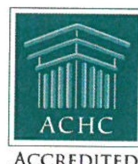
Dear Beth and Team:

Thank you for your presentations to all interested parties during the month of October. They were well received.

We as professional independent pharmacists and owners of independent pharmacies are facing an uphill battle in our quest to take care of our patients and provide the kind of medical care that our patients deserve and our profession demands. State contracts are being signed without any notification to all of the players in Florida. Independent pharmacy owners are not even invited to the "table" for our input. The contracts are being signed with only the large Prescription Benefits Managers, PBMs, whose main goal it is to make as much money as possible while failing to practice pharmacy for the benefit of our citizens. They encourage, or should I say "force" patients to procure a 90-day supply of medicine. (Examples of this will be supplied upon request) This has resulted in contamination of our water supply as unused medications are poured down the sink drains or put into the garbage. The DEA has frequent drug "take-back" days where excess drugs are taken back. The latest such day resulted in TONS of unused medication in Florida alone. Is this saving money? No, you and I are paying for this with our tax dollars. Young people get started on drugs by taking medication from their parent's pharmacy cabinets and now one (1) in 2,500 get "hooked" on prescription drugs every day in the USA.

As a practicing pharmacist for the past 54 years and owner of two pharmacies and other health care entities, I have seen this situation worsen until now where the big three PBMs now control over 80 % of all dispensed prescription drugs in the US. They decide what will be on the drug formulary, what the physician can order, how the patient will get their drugs and WHO can be in their networks to dispense those drugs. Can this be part of the reason that bad health care is the 3rd biggest cause of death in the U.S?

Conveyor belt- style shipping of pharmaceuticals should not be like shipping dog or cat food. Florida law requires us to consult with patients when we dispense medications but that is not happening. This is a violation of Florida Statutes.



We have addressed the terrible medical care that these patients get with the PBM driven pharmacy services, but now let's address the unfair way in which our own State of Florida treats the over 13,000 pharmacists and employees who live and work in Florida. They have pharmacy businesses which support the citizens and communities of the State of Florida- not to mention pay substantial taxes and salaries here. These are the same people who make the State of Florida a great place to live. Every day independent pharmacies have to close their businesses and their doors. You should check the Board of Pharmacy for the number of licenses that have been turned in.

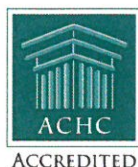
Should pharmacists be forced by the "big box" stores to work under conditions whereby they have 12 ½ hour shifts and are not allowed to sit down at any time during the work day because they will then have to work for non-health care professionals in the large chain stores. I hope that you don't think so.

Provider networks (insurance and PBMs) are being restricted and closed on an ongoing basis and nothing is being done about it because the PBMs do not have any oversight by any state regulatory agency. Despite the legislation regarding their activities to pay the pharmacies depending on the price of the pharmaceuticals, various schemes have been devised to counter that and "no one can or will do anything about it". Even the Attorney General's office does not recognize the issue despite the fact that U.S. Attorneys from other states are investigating the issues because of the flagrant abuses of the anti-trust laws.(See attached)

In our own case, we have had patients under our care transferred to PBM pharmacies without our knowledge or their consent. We have taken care of many of these patients since they were infants. This may be the fate of more than 3 million Floridians who may be forced to leave their community or personal pharmacist to go to a mail order or other pharmacy which may be owned by the PBM or insurance company where the care will be suboptimal resulting in more physician visits and higher hospitalization rates.

The Florida Pharmacy Independent Network (FIPN), along with Pharmacy Choice and Access Now (PCAN), and PPSC who works with many pharmacy organizations all want to work with AHCA to help make the MMC what it should be...improved patient access to coordinated care, promote quality and efficiency for health for all Floridians, enhance performance and access to primary care through robust provider networks, engage patients in their own care and wellness, enhance financial management and fiscal predictability, and increase transparency and accountability.

We strongly request that Florida Community Pharmacies be allowed to qualify and participate in MMC health plan pharmacy networks based upon their individual credentials so that they may help and provide exceptional medical care to the most vulnerable patients. Patients should have freedom of choice to choose their provider- one who understands them, factors surrounding their illnesses, the family environment and their financial situation so that that they will thrive in the best circumstances.



ACCREDITED

No, it is not just a drug which gets you well and hopefully cures your illness; it is also the art of pharmacy and the caring and support that a true professional gives. Then perhaps we will reduce the tremendous rising costs of health care in this state and country.

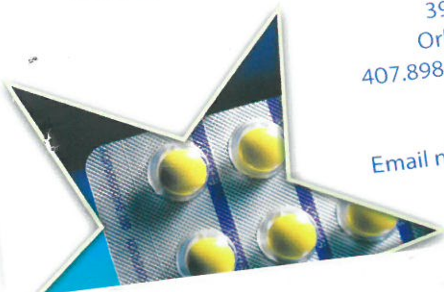
We respectfully request- on behalf of our independent pharmacists and the more than 1300 small business pharmacies, that the Agency for Health Care Administration, take action to stop the exclusionary pharmacy networks and modify its 1115 Waiver Request to require the MMC plans to operate open pharmacy networks that benefit Medicaid recipients, the Agency for Health Care Administration and all of its citizens.

Very truly yours,

N. Lois Adams, B.Pharm. MBA CRPh

N. Lois Adams, B. Pharm. MBA
President/CEO
HHCS Health Group of Companies, LLC
Cystic Fibrosis Pharmacy, Inc.
Freedom Pharmacy and Wellness Center, Inc.
Freedom Specialty Pharmacy
Medi-Paws, Inc.
HHCS Research Institute, Inc.
Medical Management Enterprises

Vice President
Florida Independent Pharmacy Network



N. Lois Adams, CRPh, MBA
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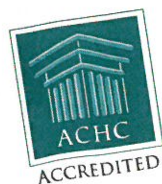

BUSINESS INSIDER

The Feds are starting to dig in at the biggest middle-man in the pharmaceutical game

LINETTE LOPEZ
OCT. 25, 2016, 5:50 PM

Preet Bharara, U.S. Attorney for the Southern District of New York, is photographed after speaking at the Crain's Business Forum in Manhattan, New York

Thomson Reuters

The Feds are gunning for the biggest middle man in the American pharmaceutical game, Express Scripts, according to government filings published on Tuesday along with the company's earnings.

Express Scripts is the largest pharmacy benefit manager (PBM) in the country.

It's used by insurers and employers to try and keep a lid on what they spend on pharmaceuticals. It also has its own internal mail-order pharmacy, and manages patient assistance programs for drug companies.

All of that has made it an behemoth.

And all of that is what's worrying politicians Washington and other federal agents. Both the US Attorney's Office for the Southern District of New York and the Department of Justice and US Attorney's Office for the District of Massachusetts want to know more about the company's client payment plans, pricing structures, and its patient assistance programs.

These are all issues that have come up over the last year as drug price hikes have become part of our national conversation. Usually, however, that conversation centers around pharmaceutical firms, not the middle men that distribute the drugs.

From the company's filings:

> On August 15, 2016, the Company received a civil investigative demand from the United States Attorney's Office for the Southern District of New York, requesting information regarding the Company's relationships with pharmaceutical manufacturers and prescription drug plan clients, and payments made to and from those entities. The Company intends to cooperate with the inquiry and is not able to predict with certainty the timing or outcome of this matter.
>
> On September 12, 2016, the Company received a subpoena duces tecum from the Department of Justice and United States Attorney's Office for the District of Massachusetts requesting information regarding relationships between pharmaceutical manufacturers, independent 501(c)(3) charitable foundations providing cost-sharing assistance to federal health care program beneficiaries, and specialty pharmacies. The Company intends to cooperate with the inquiry and is not able to predict with certainty the timing or outcome of this matter.

Express Scripts is already being sued by one of its largest clients, Anthem Insurance, for unfair dealing in their contract. That's just one of a few suits in which clients or whistleblowers accuse Express Scripts of taking advantage of its power and the lack of price transparency in the industry.

This is a huge deal in Washington, and not just because of recent scandals with EpiPen and Martin Shkreli. Republicans in Congress have been causing a stink about Express Scripts and other PBMs because they believe their vertical integration is giving them too much power and killing competition. Democrats worry that PBMs could be part of the reason why drug prices are so high, which is part of what's threatening Obamacare.

With these two investigations, we can expect more clarity as to whether or not those concerns are valid.

We should also note, by the way, that while the number of prescriptions Express Scripts declined in the third quarter, but the company beat earnings anyway on profits. That should tell you something.

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Sun Prairie, WI 53590 | 800.755-1531 phone
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November 10, 2016

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

Attn: Beth Kidder

The Independent Pharmacy Cooperative (IPC) is a national trade group representing the interest of over 5,000 independent pharmacy store owners in all 50 states. Among the services IPC provides to our member stores is legislative and regulatory advocacy on federal and state legislative and regulatory issues that affect independent pharmacy through our Government Relations Department.

On behalf of our hundreds of independent pharmacy store owners in the State of Florida, , IPC is submitting the following formal written comments on the proposal for ACHA to develop a new Medicaid Managed Care (MMC) contract through a MMA Section 1115 waiver extension

IPC appreciates the chance to provide our comments on areas where AHCA's contact with MMC program health plans should be revised to better serve Florida's vulnerable Medicaid population to help achieve AHCA's goals and initiatives of:

- Improve recipient access to coordinated care
- Promote an integrated health care delivery model that incentivizes quality and efficiency
- Enhance performance and access to preventative and primary care through robust provider networks
- Improve health outcomes through care coordination and recipient engagement in their own health care
- Enhanced fiscal predictability and financial management
- Increased transparency and accountability

IPC does see an important opportunity with the review and proposal for new MMC contracts with health plans for AHCA to achieve many of these objectives, especially to have great performance and access to care through

robust networks and to increase transparency and accountability in the program.

As your agency is aware, several MMC plans have placed severe restriction on the number of pharmacies that can participate in their MCC prescription provider network in the various Medicaid regions throughout the Sunshine State. IPC strongly urges AHCA to require in the new MMC plan contracts that MMC health plans and their pharmacy benefit managers be required to provide all Florida pharmacies with the right to enter into a contract in their MMC provider network.

Currently, many Florida MMC beneficiaries are subjected to having to travel great distances and spend a significant amount of time to obtain their Medicaid prescription from a narrow number of restrictive network participating pharmacies. We have heard numerous accounts from our Florida members that Medicaid beneficiaries have had to not only go to a different town for a Medicaid prescription, but in some regions they have had to travel miles and face significant travel time to other counties in their Medicaid region to find a MMC participating pharmacy. This situation occurs despite our members meeting credentialing requirements, CMS Five Star quality measures and being more than willing to accept MMC health plan contract terms and conditions.

The current contract conditions are estimated to force more than 3 million Floridians to leave their community pharmacy and go to different pharmacies or be forced into mail order pharmacies that are chosen by their MMC plan rather than to have the choice of how to most conveniently and effective receive their Medicaid prescriptions in a timely manner in their own communities. Such restrictions jeopardize health care outcomes, treatment compliance and coordinate care quality and efficiencies by taking the prescription component out of the community and in the case of mail order completely out of the State of Florida. These restrictions are not created to serve any reason than to financially benefit the health plans and their PBM's. These restrictions on competition raise the cost of Medicaid prescription costs rather than saving money and reduce the tax contributions of Florida pharmacies to the State and their communities.

An additional change in the contract to enhance fiscal predictability and financial management and increase transparency and accountability would to mandate that the MMC contract reimbursement terms for covered outpatient prescriptions utilize the reimbursement methodology that the State of Florida will have to adopt for the Medicaid prescription fee-for-service

program by April of 2017. By utilizing NADAC prescription drug ingredient cost AAC based reimbursement and an cost of dispense (COD) based dispensing fee in these MMC contracts, AHCA will be able to have budgeting predictability and, more importantly, transparency and accountability in the prescription portion of the MMC health plans capitation rates. With this change, AHCA will be able to efficiently relate their MMC prescription drug spend to its Medicaid FFS prescription expenditures to ensure that Florida Medicaid is spending efficiently for all its Medicaid prescriptions.

IPC stands ready to work with the AHCA to have a more robust pharmacy provider network in the Florida MMC program and to have greater transparency accountability.

Thank you for your consideration of these comments.

Sincerely,

John Covello
Director of Government Relations

United to Advance Health Care and Pharmacy Practice

November 10, 2016

Via email - FLMedicaidWaivers@ahca.myflorida.com

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

Re: Written Comments on AHCA's 1115 MMA Waiver Extension Request

Dear Ms. Kidder:

These written comments are provided on behalf of the Florida Pharmacy Association, Inc. ("FPA"), a not-for-profit corporation organized under the laws of this state which seeks to preserve and advance the practice of pharmacy and serves the professional needs of all pharmacists, pharmacy students, and pharmacy technicians in Florida. The FPA acts as the primary voice for approximately 1,300 independent community pharmacies in Florida and has hundreds of independent community pharmacy members.

The purpose of this letter is to convey our continued support of AHCA in its ongoing effort to improve the Florida Medicaid program and strengthen protections for Medicaid recipients. In furtherance of this support, we would like to highlight a troubling trend among Medicaid managed care plans that is impeding AHCA's ability to improve the MMA program and harming Florida's must vulnerable citizens. We also provide suggested actions that we feel will remedy this difficult problem.

As you well-know, as early as 2012, managed care plans began excluding independent pharmacies from participating in the managed care plans' pharmacy networks. Since then, this practice of excluding independent pharmacies as has expanded throughout the state. Please recall that numerous pharmacists voiced this very concern at AHCA's public forums on the 1115 MMA waiver extension. The exclusions are not based on quality of care, cost, credentials, or any other lawful or legitimate basis, and have resulted in plan participants being funneled into closed pharmacy networks, thus removing their freedom to choose their pharmacy providers. In many cases, plan participants who have longstanding relationships with independent pharmacies have been forced to find new providers.

Studies show that patients who have longstanding relationships with their pharmacists understand how their medications help them and, as a result, receive better healthcare outcomes. When this relationship is disrupted by unjustified plan closures, the patient must develop a new relationship with a chain pharmacy that, oftentimes, does not have the time

needed to become familiar with the patient's health history or unique needs. This results in poorer healthcare outcomes and increased costs to the state.

We have a solution. Current law prohibits managed care plans from unjustifiably excluding independent pharmacies from participating in the pharmacy networks. Section 409.975(1), Florida Statutes, governs provider networks for Florida's Statewide Medicaid Managed Care program and provides, in relevant part that "managed care plans may limit the providers in their networks based on credentials, quality indicators, and price." (Emphasis added). This statute prohibits managed care plans from excluding pharmacies for any reason other credentials, quality indicators, and price. In essence, this statute authorizes any willing and qualified pharmacy to participate in the plans. Unfortunately, credentialed pharmacies that meet the plans' quality requirements and are willing to accept the plans' reimbursements have been excluded from participation for no legitimate reason. AHCA should immediately begin enforcing section 409.975(1) by prohibiting plans from excluding pharmacies for any reason other than credentials, quality indicators, or price.

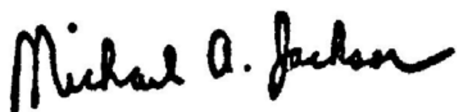
While we are aware that the 1115 waiver may allow for exempting the state Medicaid program from the federal any willing provider requirements, section 409.975(1) does not provide for a similar exemption. Thus, despite an exemption from the federal any willing provider requirements, the plans must still comply with the Florida any willing provider requirement.

Further, we believe that AHCA should incorporate the any willing provider requirements of section 409.975(1) in its application to extend the 1115 MMA waiver and into the MMA plan contracts in the next cycle of contract amendments.

In sum, we respectfully request that AHCA: 1) immediately begin enforcing section 409.975(1); 2) incorporate the requirements of the statute in its application to extend the 1115 wavier; and 3) incorporate the requirements of the statute in the next cycle of contract amendments. These actions will enforce existing law while improving patients' healthcare by providing them with greater access to quality pharmacies without increasing costs.

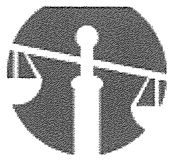
Finally, we would like to reiterate our support for AHCA in its efforts to improve the Medicaid program. We believe that by adopting our requests, AHCA will achieve the legislative intent of section 409.975(1), Florida Statutes, and, most importantly, will improve the quality of care for Florida's Medicaid population. Thank you for your consideration of these comments and we look forward to continuing to work with you on these important issues.

Sincerely,



Michael A. Jackson, BPharm
Executive Vice President and CEO

CC: FPA Board of Directors



FLORIDA LEGAL SERVICES, INC.

SHIRLEY SPUHLER HEALTH CARE FAIRNESS PROJECT

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ERIC SODHI
PRESIDENT

CHRISTOPHER M. JONES
EXECUTIVE DIRECTOR

November 10, 2016

VIA ELECTRONIC SUBMISSION FLMedicaidWaivers@ahca.myflorida.com

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

Re: Florida Managed Medical Assistance Program 1115 Research and Demonstration Waiver 3 year extension request comments

Dear Sir/Madam:

Florida Legal Services (FLS) is a statewide public interest law firm that advocates on behalf of low-income individuals and families on a range of health-related matters, including Medicaid. Through our FLS Prescription Helpline we work in collaboration with physicians, pharmacies and Medicaid recipients throughout Florida to obtain coverage for necessary prescriptions that have been denied. We appreciate this opportunity to comment on the MMA Waiver Extension Request and share our concerns regarding pharmacy network restrictions.

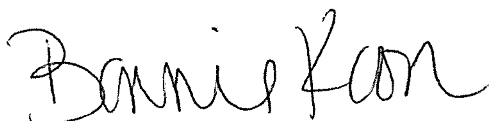
Through the FLS Prescription Helpline, we often encounter issues with Medicaid recipients who are unable to access a local pharmacy due to pharmacy network restrictions set by the recipient's MMA Plan. Some towns only have local independent pharmacies and do not have the large chain pharmacies which most plans consider in-network. Unfortunately, many of these local independent pharmacies are unable to fill MMA recipient's medications because of these pharmacy provider/network restrictions.

For example, one FLS Prescription Helpline client is unable to fill her medications near her home because they are not in the network of her MMA plan. The closest "in-network" pharmacy to her home is twenty miles away. This client is also disabled, on a fixed income and without her own transportation. She has had to rely on a friend to assist her with transportation to and from the pharmacy multiple times a month to obtain her necessary medications, despite having several "not in-network" pharmacies less than five minutes from her home.

The Agency for Health Care Administration (the Agency) has made it a goal to "Enhance access to primary and preventive care through robust provider networks" in the public meeting documents for this waiver extension request. Unfortunately, in the same document the word pharmacy is not mentioned once. Our experience assisting FLS Prescription Helpline clients have indicated to us that SMMC recipients, particularly those living in rural areas, do not have access to robust pharmacy networks. The special consideration the Agency is required under 409.912 (8)(a)4, F.S., to give rural areas in determining the size and location of pharmacies appears to be lacking.

Recommendation: We recommend that the Agency review the current pharmacy networks, particularly those in rural areas, to ensure that the intent of 409.912(8)(a)4 is achieved and that SMMC recipients living in rural areas are able to access pharmacy providers without traveling unreasonably, lengthy distances. We also request that the Agency consider decreasing the Provider Network maximum distance and time standards for rural county pharmacies. Requiring SMMC recipients to travel twice as far and twice as long has urban-dwelling recipients in order to access necessary medications in not acceptable -- particularly when other willing pharmacy providers are closer in proximity.

FLS appreciates your efforts for increased provider networks. Thank you for your consideration of these comments and recommendation.



Bonnie Koon
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FLORIDA LEGAL SERVICES, INC.

THE CHILDREN'S HEALTH CARE ACCESS PROJECT

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ERIC SODHI
PRESIDENT

CHRISTOPHER M. JONES
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November 10, 2016

VIA ELECTRONIC SUBMISSION FLMedicaidWaivers@ahca.myflorida.com

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

Re: Florida Managed Medical Assistance Program 1115 Research and Demonstration Waiver 3 year extension request comments

Dear Sir/Madam:

Florida Legal Services, Inc. (FLS) is a statewide public interest law firm that advocates on behalf of low-income Floridians, including children. Through our FLS Children's Health Care Access Project we work in collaboration with local legal services programs and other children's advocacy organizations throughout Florida on an array of children's health care issues, including access to care and services under the Florida Statewide Medicaid Managed Care (SMMC) program. In addition to more generally applicable comments FLS has submitted separately relating to Florida Medicaid's Request to Extend the 1115 Managed Care Waiver (Extension Request), we submit the following comments highlighting particular areas of concern relating to children's access to health care that we've identified through our FLS Children's Health Care Access Project advocacy work.

Increased Education and Outreach on MMA Consumer Protections

We appreciate and applaud the work the Agency for Health Care Administration ("the Agency") has done under the Statewide Medicaid Managed Care Program to educate stakeholders and increase transparency of the process and plan performance. The additions of the "Medicaid Landing Page" and the "Recipient Resource Page" on the Agency website have been particularly helpful by providing a consumer-oriented section of the website where recipients and other stakeholders can easily access Medicaid coverage and health plan information, initiate an SMMC

complain, and obtain information on important consumer protections, including how to make a complaint about the SMMC program. We also commend the Agency's significant efforts to provide increased trainings and webinars on key components of the SMMC and complex coverage and service areas. The series of webinars the Agency conducted on Coordinating Access to Residential Behavioral Health Services for Children was particularly helpful and addressed many concerns and questions we, along with other children's legal services attorneys we work with, identified in helping children in foster care access behavioral health services from their Managed Medical Assistance (MMA) plans.

While this increased access to important SMMC information has been helpful, we are concerned that many recipients and other stakeholders, including providers and health plan employees, are still unaware of, or are confused about, some of the most important protections under the SMMC program – particularly the network adequacy standards and timely access requirements. We are grateful that these protections, which we believe are some of the greatest improvements and strengths of SMMC program, were put in place to ensure patients receive the medical care and services they need. However, we are concerned that the true effectiveness of these protections can be difficult to monitor and measure if Medicaid recipients are unaware of them and don't know to make complaints or file grievances when they have trouble accessing services from their health plans.

Our experiences working with families with children having trouble accessing Medicaid services have indicated to us that there is still cause for concern that Medicaid recipients may be experiencing inadequate network and timely access problems but not reporting them. We have found that most recipients we've assisted under the SMMC were unaware that their health plan is required to a have a sufficient network of providers to provide all Medicaid covered services to enrollees with reasonable promptness. Most of the recipients we worked with were also unaware of the timely access standards requiring plans to assure that services are available within one (1) day for urgent care, one (1) week for sick care, and one (1) month for well care visits.

Recipients are not alone in being unsure about these protections. In helping children access Medicaid services under SMMC, we have encountered providers, health plan employees, and child welfare case workers – some of whom were actually in customer service positions or responsible for working directly with recipients to help them access services – who were completely unaware of these protections and who provided recipients with inaccurate information that conflicted with the network adequacy and timely access standards in the health plan contracts. This is particularly alarming given that patients seeking health care generally assume (and should be able to assume) that they are receiving accurate information from their health care providers and health plans. When Medicaid recipients are told by providers or health plan employees that they can't get an appointment or access care for months, it's very likely that most patients, while frustrated, will accept this information as correct. Indeed, many of the

SMMC recipients we've worked with who were having trouble accessing services did not realize that their plans were violating timely access standards and that they had a right to complain about the delays they were experiencing in accessing services.

Increase outreach and education about these consumer protections is necessary to ensure that recipients understand them and can recognize and report provider network inadequacies and timely access violations. We urge the Agency to include detailed information about these important consumer protections on the consumer oriented sections of the Agency website. The Recipient Resources page would be the ideal place to include information about SMMC recipients right to timely access to care and network adequacy requirements. Additionally, it would be helpful to include this information on the SMMC enrollment website, www.flmedicaidmanaged.com. Currently, the homepage of this site highlights the SMMC complaint process and MMA Dental Services by providing recipients with a link to additional information on these subjects. SMMC consumer protections could also be highlighted in a similar manner here with a link to detailed descriptions of provider network adequacy standards and timely access requirements, along with actions recipients should take when they are unable to access medically services in timely manner.

We recognize that the Agency alone can't be responsible for all the education on these consumer protections. All stakeholders working with Medicaid beneficiaries need to be committed to understanding SMMC consumer protections and effectively communicating them to consumers. MMA health plans and medical providers must be responsible for ensuring that their staff who work directly with recipients or in customer services roles are adequately educated on SMMC consumer protections and providing consumers with accurate information. We urge the Agency to modify health plan contracts to increase the plans' responsibility to educate their members about the timely access and network provider protections, and to ensure their customer staff are properly trained. We also encourage the Agency to include in its secret shopper initiatives activities to verify whether health plan customers services representatives are sufficiently educated on key SMMC consumer protections and providing accurate information to recipients who seeking their assistance.

We also recommend that the Agency take a closer look at the efforts of other state agency partners in educating their staff who work with SMMC recipients and increase outreach and education efforts where necessary. Our experiences working with children in the child welfare system have indicated to us that, in general, the staff at Community-Based Care organizations, particularly those responsible for helping foster children access the care and services they need, are not sufficiently trained about the SMMC program and the protections and benefits it provides children. Often, the CBC staff we encounter in working with children in foster care are not only unaware of timely access and provider network requirements, but many are also confused about the appeal process and have little to no understanding of the EPSDT medically necessary

standard for children. We encourage the Agency to reach out to these partners and work with the Department of Children and Families to ensure that CBC staff have a better understanding of EPSDT and SMMC protections and are effectively working to ensure that the children in their care are receiving medically necessary care and services.

Dental Care for Children

Given Florida's consistent failures in adequately providing dental services to children enrolled in Medicaid, FLS is concerned that the Waiver Extension Public Notice Document understates the significant problem Florida still faces in providing Medicaid dental services to children. While we recognize that there have been significant improvements made in providing dental services to children since the implementation of the SMMC, the fact remains that Florida's performance in this area is abysmal and most MMA health plans have not done enough to improve their embarrassingly poor performances with regard to dental care.

Florida's most recent Annual EPSDT Participation Report Form CMS-416 for Fiscal Year 2015, show that, despite improvements, Florida is still failing its children in providing dental services under Medicaid. According to that report, 2,403,286 children were eligible for the Medicaid EPSDT program for ninety (90) continuous days in 2015, yet only 745,528 of these children received preventive dental services, and only 831,913 of these children received any dental services. Simply put, over 1.5 million of the 2.4 million children enrolled in the SMMC program aren't receiving preventive dental services. Since these children aren't receiving the preventive services they need, it is virtually impossible to estimate how many of them are going without necessary dental treatment.

While the Agency and plans should be proud of the improvements made in providing dental services to children under the SMMC, we cannot afford for only this half of the story to be told. Florida's MMA health plan dental performance rates are still far from acceptable and the Agency needs to be very clear and vocal about that fact. FLS strongly encourages the Agency to include additional language in the Waiver Extension request that more accurately describes the crisis Florida still faces with regard to Medicaid dental services for children and that places increased emphasis on the need for MMA health plans to continue to improve their dental performance rates.

Clearly, it's going to take more than what is being done to now to encourage MMA health plans to meet preventive dental services and dental treatment rate requirements. We are encouraged by the Agency's indicating in the Waiver Extension Public Notice Document that there will be "possible liquidated damages" for plans that do not meet new targets rates for preventive dental services and dental treatment services, but we urge the Agency to go farther than "possible liquidated damages" and instead mandate liquidated damages for all plans that fail to reach target rates.

Thank you for this opportunity to comment on the Waiver Extension Request and for the Agency's continued efforts to improve the SMMC program. The FLS Children's Health Care Access Project appreciates the Agency's willingness to consider our concerns and recommendations, and we look forward to continuing to work with you to ensure that all children's enrolled in the SMMC program are receiving the medically necessary services and care they need.

Sincerely,

/s/ Amy Guinan Liem

ADVOCATES FOR QUALITY MENTAL HEALTH, ALCOHOL & DRUG ABUSE SERVICES

November 10, 2016

1115 MMA Waiver Extension Request
Bureau of Medicaid Policy
Agency for Health Care Administration
2727 Mahan Drive, M.S. #8
Tallahassee, Florida 32308

Re: Comments on 1115 MMA Waiver Renewal (Project Number 11-W-00206/4)

The Florida Council for Community Mental Health would like to applaud the Agency for Healthcare Administration (AHCA) for the flawless implementation of the Managed Medicaid Assistance Program under the 1115 Research and Demonstration Waiver and for the submission of the renewal request. We appreciate Agency for Health Care Administration (AHCA) staff working diligently with stakeholders to develop and draft the wavier renewal request.

While we understand AHCA's rational for utilizing a regional procurement approach to implementation of the specialty plans, especially the SMI Plan, we would encourage AHCA to consider utilizing a statewide requirement for specialty plans in the procurement during the renewal period.

We support AHCA's decision to utilize a capitation rate as a mechanism to provide payment to MMA plans for services provided under the pilot program. However, we request the rate development process be fully transparent including an opportunity to participate for MMA plans, providers and other stakeholders.

As the Special Terms and Conditions component of the MMA 1115 Waiver is revised, there are several areas that we encourage CMS and AHCA to include when monitoring and analyzing the effect of managed care on access to care under the demonstration.

We strongly support the Consumer Protections as outlined in the Special Terms and Conditions of the current 1115 Research and Demonstration Waiver and request that those protections continue. We encourage AHCA to provide written clarification (and post publicly) of the coordination of care component for behavioral health services (as required in SB 12) will be demonstrated, i.e. signed agreements, memorandum of understanding, or other means and how MMA plan partnerships with managing entities, and other providers in the region will be demonstrated.

We encourage CMS and AHCA to include monitoring and evaluation of the Medicaid Fair Hearing(MFH) process as the process is redesigned. Tracking service provision after a request for a MFH is made, the outcome of the MFH, and consumer satisfaction with the MFH process will be important and we urge AHCA and CMS to consider including these metrics or similar metrics in the analysis.

316 East Park Avenue, Tallahassee, Florida 32301-1514, (850) 224-6048, FAX (850) 224-8837

We encourage CMS and AHCA to include monitoring of the application of AHCA's definition of medical necessity (as defined in Rule 59-G-1.101, Florida Administrative Code) by the MMA plans for all services provided, and to post publicly each MMA plans criteria for determining medical necessity on the AHCA website.

We encourage CMS and AHCA to include evaluation of actual payments to providers and not solely capitation payments paid to MMA plans, as well as MMA plan rates for contracted providers for the services included in the MMA program.

We encourage CMS and AHCA to include evaluating actual utilization of services that would include reporting the total number of claims submitted to all MMA plans (by plan), including the number of claims denied, rejected, suspended and paid and the amounts of the denied and the paid claims. This will allow the MMA plans to demonstrate the breadth of service provision, and allow for comparison of volume of services of MMA plans to pre-MMA. These metrics are captured on a daily basis by each MMA plan and this would not be administratively burdensome to report quarterly and annually. We encourage AHCA to be fully transparent and make the reporting available publicly, perhaps by posting these reports on the AHCA website, or via other means.

Thank you for the opportunity to participate in the public meetings and to submit comments on the Managed Medicaid Assistance Program under the 1115 Research and Demonstration Waiver. The FCCMH is appreciative of the waiver renewal request and the willingness of Agency staff to include stakeholder input in the process. We are pleased the MMA program will continue to provide necessary services to our most vulnerable Floridians.

Sincerely,

Melanie Brown Woofter
Interim President and CEO
Florida Council for Community Mental Health

FLORIDA LEGAL SERVICES, INC.

MIAMI ADVOCACY OFFICE
3000 BISCAYNE BLVD., STE. 102, MIAMI, FL 33173 - PHONE: 305.573.0092 - FAX: 305.328.6086

ERIC SODHI
PRESIDENT

CHRISTOPHER M. JONES
EXECUTIVE DIRECTOR

November 10, 2016

VIA ELECTRONIC SUBMISSION FLMedicaidWaivers@ahca.myflorida.com

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

Re: Florida Managed Medical Assistance Program 1115 Research and Demonstration Waiver 3 year extension request comments

Dear Sir/Madam:

Florida Legal Services, Inc. (FLS) is a statewide public interest law firm that advocates on behalf of low-income Floridians. This includes advocacy on behalf of uninsured Floridians (many of whom would be eligible for coverage under Medicaid expansion) who rely on safety net hospitals and who are directly impacted by Florida's Low Income Pool program (LIP).

We are puzzled that the Agency is not requesting waiver or expenditure authorities related to LIP. The *Public Notice Document* states that "[t]he Agency was notified by CMS in June 2015 that the authority for the LIP program would be for two years only (i.e. not extending past June 30, 2017)." We are familiar with that letter but were under the impression that the Centers for Medicare and Medicaid Services (CMS) altered this position during subsequent negotiations which culminated in the October 2015 amended Special Terms and Conditions (STCs) related to LIP.

We understand that CMS was not willing to continue funding the LIP program at a level that would have included reimbursement to providers for the cost of treating uninsured Floridians who would be eligible for coverage under an expanded Medicaid program. We agree with CMS' major principle in reviewing LIP waiver requests from any state, i.e. coverage rather than supplemental payments is a better use of public funds. However, it is beyond dispute that states

such as Florida have a large number of residents who are not eligible for Medicaid expansion, and some uncompensated care pool is therefore necessary.

Accordingly, the size of LIP was reduced from approximately $1 billion to approximately $600 million, which includes significant and necessary federal matching dollars. Thus, while CMS will not restore the size of LIP to its prior levels, it is our understanding that the October 2015 STCs addressed CMS' other concerns regarding Florida's LIP program (e.g. lack of monitoring and transparency) and left open the opportunity to request a renewal.

As consumer advocates, we believe that the October 2015 STCs related to Florida's LIP program provides significant improvement over Florida's prior LIP program in terms of ensuring that funds are used only for the costs of treating the uninsured (rather than for a Medicaid "shortfall"), along with improved monitoring and transparency.

Our only question/concern regarding the current LIP program is that the tiering structure injects unnecessary complexity into the program and provides a disincentive to counties whose LIP recipient hospitals are in Tiers 2-4, from submitting Inter-Governmental Transfers (IGTs). It may be difficult (or impossible) for hospitals that are not in Tier 1 to receive the hospital's potential LIP allotment, and it appears that several of these hospitals are critical to their community's safety net.

We are aware that the Medicaid Agency recently submitted a legislative budget request regarding Medicaid supplemental payments to hospitals. The Agency's narrative similarly states that "the federal government… has indicated they would not continue the LIP program beyond June 30, 2017." Thus, the Agency "proposes to continue Medicaid supplemental payments to hospitals utilizing a directed managed care pass-through payment." The proposal would have the state match provided by IGTs (as with LIP) and managed care plans would make payments to hospitals through a per member per month pass-through built into the contract and which would be equivalent to the current LIP amount, $607.8 million. The narrative cites to 42 CFR Parts 431, 433, 438, 440, 457, and 495 as authority. However, it is not yet clear if/how these new managed care regulations address consumer concerns - at least to the degree provided by the current LIP program STCs.

For the reasons stated above, we recommend that the Agency reconsider its decision to exclude LIP from this renewal request.

Thank you for considering these comments.

Respectfully submitted,

s/Miriam Harmatz

Miriam Harmatz
miriam@floridalegal.org

Three-Year Extension Request and Public Input: Florida's Medicaid's 1115 Managed Care Waiver

Justin Senior, Interim Secretary
Beth Kidder, Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Dr. Mail Stop #8
Tallahassee, Fl. 32308
FLMedicaidWaivers@ahca.myflorida.com

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IMPORTANT HIGHLIGHTS

- The 1115 Managed Care Waiver renewal request is incomplete due to a lack of evaluation.
- Increased transparency is vital. Critical pieces of information about SMMC need to be more easily accessible by the public.
- The State of Florida should pursue Medicaid expansion to supplement or replace Low Income Pool finding.
- Under Florida's statewide managed care progrm, insufficient network adequacy & access to providers persists as major concerns.

Re: Florida's Three Year Waiver Extension Request; Managed Medicaid Care AssistanceProgram, Project Number 11-W-00206/4

Dear Secretary Senior, Deputy Secretary Kidder & Ms. Glaze:

This comment letter is submitted on behalf of Florida CHAIN (Community Health Action Information Network), The Florida Center for Fiscal and Economic Policy, and the Florida Health Alliance. Florida CHAIN is a statewide consumer based health care advocacy organization dedicated to promoting access to affordable and quality care for all Floridians.

General Comments:

We commend the Agency for Health Care Administration ("AHCA" or "the Agency") for its extraordinary efforts on multiple fronts over the life of this demonstration to better serve Florida Medicaid recipients. In particular, we want to recognize the Agency's activities to reach out to more consumer and advocacy groups; to increase staff resources dedicated to improved functioning of the Medical Care Advisory Committee (MCAC); to use the complaint hub as a tool for identifying and responding to trending problems and; to increase transparency through the posting on the Agency website of information about the Statewide Medicaid Managed Care (SMMC) program.

But substantial work remains. There continues to be a stark disconnect between the picture painted by AHCA of how well the SMMC program is serving Medicaid recipients and the actual experience of many recipients and providers. Findings based on a Medicaid Managed Care Roundtable hosted at the Children's Board of Hillsborough County on August 24, 2016 (bringing together health and human services organizations, advocates and Medicaid recipients) highlight problems with enrollment, network adequacy, reimbursement, access to mental health, dental care and other specialty services, lack of care coordination for persons with chronic and complex diseases, prior authorization, among other things. See also e.g., How is Florida's Medicaid Managed Care Working for Children, Georgetown University, Center for Children and Families, June 2016, http://bit.ly/CCFReport, and 2 Million Kids, $24 Billion Battle, Maggie Clark, Sarasota Herald Tribune, January 17, 2016, http://bit.ly/medicaidkids. These complaints represent real systemic problems that should not be characterized as isolated anecdotes.

Below are specific areas of concerns and recommendations that we have identified through our contact with recipients, providers, health care experts and other advocates:

Renewal Request is Incomplete Due to a Lack of Evaluation

The Public Notice Document, available at: http://bit.ly/AHCAPubNotice states: "[a]t this time, no evaluation reports have been completed and therefore there are no findings to report." This is contrary to federal regulations and current waiver terms requiring that the state submit an interim evaluation report as part of the request for renewal of the demonstration, 42 C.F.R. § 431.424(d), as well as current waiver terms including detailed requirements for the evaluation. (Special Terms & Conditions, STCs 104-107).

The evaluation is an essential piece of information for the federal Centers for Medicare & Medicaid Services (CMS) and all stakeholders to gauge if and how the demonstration waiver is meeting its goals, what is innovative about the project and whether it continues to be innovative. This is especially true when, as here, the Agency requests to continue the program "as is" except for elimination of the Low Income Pool (LIP). The PND specifically highlights risk-adjusted premiums and the healthy behaviors program as the "demonstration components" of the program (PND, p. 3). We question whether these components continue to be innovative. (e.g., 42 C.F.R. § 438.5 already permits the state to use a "risk-adjusted" methodology to set rates and; the plans' healthy behaviors programs have very low enrollment, particularly for the programs mandated by the waiver terms- smoking cessation, weight loss and substance abuse treatment)

We recommend that the Agency at a minimum provide more public information about the evaluation design and process during the time it is considering the renewal request and permit continued public comment on the evaluation.

Implementation of New Federal Medicaid Managed Care Regulations

CMS recently adopted sweeping regulatory changes for the Medicaid managed care program. These new requirements impact numerous aspects of Florida's demonstration including, but not limited to, quality and performance measures, consumer rights and protections, program integrity and state oversight.

While Florida is "ahead of the curve" in implementing these new regulations, because many of the requirements have been incorporated into the waiver STCs, a number of program changes are still needed to bring Florida into compliance. The waiver extension request provides opportunities for Florida to stay ahead of the curve by "piloting" with CMS implementation of the new requirements on a more accelerated basis than what is set out in the new rules.

For example, CMS will be developing a new quality rating system including measures that are tailored to special populations served by Medicaid (e.g., children, pregnant women, seniors and people with disabilities). States may adopt the CMS model or create an alternative system which provides substantially comparable information as the CMS model. Florida already has a quality rating system. We urge AHCA and CMS to review Florida's current rating system, and work with consumers and providers to identify needed modifications to improve the system and develop an implementation plan and phase-in. Notably, there is no mention in the PND of the specific work needed at the state level to fully comply with the new regulations.

We recommend that at a minimum, the Agency prepare (if it hasn't already done so) and publicly disseminate an inventory and cross-walk of the specific programmatic changes needed to comply with the regulations, an implementation plan and schedule. In addition, opportunities for consumer/stakeholder input should be identified for particular program changes needed.

Increased Transparency

Although progress has been made on this front, critical pieces of information about SMMC need to be more easily accessible by the public. This is essential to countering skepticism about the program and the perception that the Agency is not doing enough to proactively oversee the SMMC program and make improvements.

For example, AHCA recently presented to the MCAC a draft compliance report for FY 2015-16 including information on the types of complaints leading to agency enforcement action, the specific plans subject to compliance actions and the "action types" (sanctions, liquidated damages, corrective action plans). It is anticipated that the final report will soon be posted on the Agency's website for general public access and review. We applaud the Agency for moving in this direction and *recommend more transparency in this area, including posting of plan corrective action plans.* This will allow increased participation of by both consumers and providers to ensure that needed changes actually occur.

Other information which needs to be more accessible is encounter data, agency analysis of this information, and medical loss ratio statistics. The Agency has kept this information very "close to the vest" making access to it by the public extremely difficult.

The new federal regulations include numerous website posting requirements relating to plan compliance with availability and accessibility of service requirements, quality measures and performance outcomes, plan contracts, plan ownership and control information, including subcontractors and audit results. *Work needed to come into full compliance with these new website posting requirements should be included in the inventory and regulation implementation plan recommended above.*

Insufficient Network Adequacy & Access to Providers

There continue to be numerous complaints on timely access to a range of specialists, including, but not limited to, mental health, dental care, dermatology, orthopedics and therapies (speech, occupational and physical therapies). Medicaid managed care was intended to remedy these problems, but they persist and in some cases are worse. Also, many plans rely on subcontractors to provide specialty therapies and other services. This presents an additional challenge in monitoring the adequacy of provider networks.

At the recent MCAC meeting, we were pleased to hear that *AHCA is pursuing "secret shopper" activities to verify the accuracy of provider directories and networks. These activities need to continue and expand, including monitoring of subcontractor networks. Similarly, activities of the External Quality Review Organization (EQRO) to validate network adequacy need to be greatly expanded beyond just hospital networks (see p. 24 of the PND), as required by 42 CFR § 438.358, to include other services, providers, and subcontractors.*

Under the new federal regulations, states have a responsibility to ensure that each plan maintains and monitors a network of appropriate providers sufficient to provide access to all services covered under the contract and if unable to do so, provide access to them out of network. Plans are required to submit documentation to the state to support compliance with network adequacy and time and distance standards and the state is required to review this documentation and certify that the plan is in fact compliant. 42 C.F.R. § 438.206-.207 & § 438.68. Although these regulations do not have to be implemented by states until 2018, *we urge AHCA to continue staying "ahead of the curve" by implementing these provisions sooner and addressing the ongoing and urgent access problems for Florida Medicaid recipients.*

We are pleased that AHCA is providing the health plans an opportunity to provide services through telemedicine. Our understanding is that the plans can make specific proposals to the Agency for its approval. *We recommend that the Agency develop and implement a strategic plan for piloting the use of telemedicine to specifically expand network capacity where there is a shortage of providers for particular services. (See specialty services identified above.)*

Coordinating Care for those with Complex Medical Needs

Although the plan contracts include specific requirements around care coordination for special populations, the reality falls short. It is still new territory for many of the plans which have historically predominantly served commercial healthier populations.

As an initial matter, *we urge the Agency to review current contract provisions to ensure compliance with new care coordination requirements included in the new federal regulations and adopt needed contract amendments.* The regulations expand requirements for coordinating care for enrollees. 42 C.F.R. § 438.208 (b) & (c). Plans are required to: conduct a screening within the first 90 days of enrollment to identify the enrollee's needs; ensure that the enrollee has an ongoing source of appropriate care; and designate a person or entity to be primarily responsible for coordinating the enrollee's services. The designee must coordinate services provided to the enrollee, care during transitions from one setting to another, services the enrollee receives from another managed care plan, any carved-out services and community/social supports. The new rule also includes special procedures for plans to follow for enrollees with special health care needs and those using long term services and supports.

There are particular barriers to timely care for children with special needs who are enrolled outside of the CMS network plan and "dual eligibles" - elders and persons with disabilities who are covered by both Medicare and Medicaid. Too many are unable to access specialty care which undoubtedly relates to network insufficiency problems. Frequently efforts at "care coordination" are futile when there just aren't any available providers to meet enrollees' needs. (e.g., a person with a g-tube who cannot access the services of a gastroentologist).

Dual eligibles, as well as their care managers, have enormous difficulties sorting out what Medicare covers vs. Medicaid, what services their Medicaid plan will cover and finding providers that will accept their Medicare and Medicaid. (not balance bill them). It has been brought to our attention that durable medical equipment is a service that is especially difficult for dual eligibles to navigate and access.

The Agency is moving towards mandating more enrollment of special populations into the SMMC program. (For example, AHCA's latest legislative budget request indicates that it is seeking to move people on the Brain and Spinal Cord Injury Waiver Program into the SMMC program.) It's all the more critical for AHCA to be drilling down on what is really happening on the frontlines for these special populations through focused audits. *These audits need to review how are plans identifying persons with special needs, assessing them and implementing treatment plans to ensure that their needs are met. Based on the audit findings, systemic solutions need to be developed in conjunction with consumers and providers for improving the "care coordination" function.*

Benefits/Services Issues

Customized benefit packages - AHCA seeks continuation of the waiver terms permitting the state to waive amount, duration and scope and comparability consumer protections in law and permit plans to "customize" their benefit packages. (STC 26-31) This is a feature that is particularly worrisome for consumers since it gives AHCA complete discretion (with no input from consumers or providers) to vary the amount, duration and scope of optional services (such as prescriptions) based on its determination of what is "medically sufficient."

We request that AHCA and CMS terminate the waiver of these legal protections and eliminate the related terms and conditions included in the current program. These provisions can be eliminated with no harmful consequences to the program since none of the plans have adopted this option for years. Further, there are no evaluation findings to demonstrate that these provisions are innovative and in the best interest of Medicaid recipients.

Plans' implementation of Medical Necessity Standards, EPSDT Standards & New Federal Regulations on Service coverage - Although plan contracts require that they comply with the federal Early and Periodic Screening Diagnosis and Testing (EPSDT) medical necessity standards, in reality, the plans have a multitude of distinct criteria and protocols they apply to make these determinations. This impacts many services and subcontractors. It is particularly problematic for children who are protected by the EPSDT medical necessity standard. They are entitled to services necessary to treat, as well as correct and ameliorate physical and mental health conditions. This is a standard quite different than those applied by commercial insurance plans and consequently there are ongoing problems with consistency across plans on services provided. For example, children in need of a specialized therapy (speech, physical or occupational) may be able to receive the services in one plan but not at all in another, or at a significantly reduced level. This is not how the program is intended to work. To get a clearer understanding of this problem as a foundation for developing solutions, *we recommend that AHCA perform an audit, comparing across plans similar child enrollee profiles, needs and services provided. Among other things, service underutilization issues need to be identified and addressed.*

We also urge the Agency to review and modify contract provisions to clarify that the EPSDT service standard is the medical necessity standard for enrollees under age 21. Current contract provisions are extremely confusing on this point and undoubtedly contribute to ongoing EPSDT implementation barriers. The contract refers to "medically necessary EPSDT services," and require plans to include this language in their enrollee handbooks. See Exhibit II-A, page 5 at: http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/Contracts/2016-08-15/08-15-16_EXHIBIT_II-A_MMA_GEN_AMEND.pdf . But the state's definition of medical necessity cannot be read consistently with the EPSDT standard. (Fla. Admin. Code R. 59G-1.010 (166) limits it to services necessary to "protect life, prevent significant illness or significant disability or to alleviate pain.") Further the contract refers plans to the Child Health Check-Up Coverage and Limitations Handbook for more information about the scope of the EPSDT benefit. Exhibit II-A, p. 22. However, that Handbook is no longer on the Agency's website or incorporated into Agency rules.

With regard to adults, new federal regulations require plans to cover services that address prevention, diagnosis and treatment of an enrollee condition and/or disorder, as well as address the ability for the enrollee to "attain, maintain, or regain functional capacity." 42 C.F.R. § 438.210. AHCA's medical necessity definition is more restrictive than the new federal requirements. This particularly hurts elders and people with disabilities.

We recommend that the new waiver terms incorporate these updated medical necessity standards and include them in all contracts with the plans. Additionally, we recommend that the Agency perform focused oversight/monitoring of the plans' implementation of these new standards.

Urgent Care Transportation - Transportation to medical services continues to be quite challenging for many recipients. Urgent care is particularly problematic. The Agency's contracts with plans require urgent care services be provided within one day of the request. Exhibit II-A, p. 87. However, it is standard for transportation providers to require a three-day advance notice in scheduling. This doesn't work for urgent care. Typically, the enrollee is trying to get into a provider office quickly and the provider is trying to squeeze them in. The enrollee usually does not have the luxury of lining up a transportation provider three days in advance. *We recommend that the Agency review the plans' urgent care policies and protocols to ensure that they support the contract one-day urgent care standard.*

Pharmacy Services - We commend AHCA for continuing to require the plans to use the Agency's preferred drug list (PDL) instead of permitting seventeen (17) different plans to develop their own PDLS/formularies. Patients and providers already have difficulties navigating a multitude of plans' varying protocols for accessing medications. See, How is Florida's Medicaid Managed Care Working for Children, Georgetown University Health Policy Institute, Center for Children and Families, June 2016, http://ccf.georgetown.edu/wp-content/uplods/2016/06/FloridaPediatricianReportJune.pdf (Access to medically necessary medications due to formulary changes was a significant area of concern for surveyed pediatricians). Undoubtedly the problem will be extraordinarily compounded if providers have to familiarize themselves with seventeen (17) different formularies in order to get coverage for medically necessary medications for their patients. *Aside from maintaining the requirement for plans to use the Agency PDL, we urge that a focused study/audit be performed to determine why pediatricians are facing challenges accessing medically necessary medications for their patients and implement strategies with the plans to address this problem.*

We also commend AHCA for including in plan contracts requirements for compliance with the *Hernandez v. Medows* settlement. This has again put AHCA "ahead of the curve" for compliance with new federal regulations pertaining to medications PA and due process when plans deny coverage for medically necessary medications.

With regard to pharmacy networks there continue to be problems for enrollees needing to access the services of independent non-chain pharmacies. These local pharmacies face difficulties getting in-network contracts with plans. As a result, enrollees, especially in rural areas, are forced to break off long-standing relationships with their local pharmacist and/or travel much greater distances to access their medications. Although the contracts already require plans to comply with the statutory requirements that special consideration be given to rural areas in determining the size and location of pharmacies included in their networks, see §409.912(8)(a)4, Florida Statutes, there are gaps in plan compliance with this provision. *We recommend that the Agency review plan pharmacy networks for inclusion of independent pharmacies and implement necessary related contract modifications or other policy changes.*

Adult immunizations - Florida's Medicaid program is the only program in the country that does not cover any adult immunizations. This is contrary to numerous recommendations by national experts including the Centers for Disease Control and the Adult Vaccine Access Coalition. See, http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf ; http://www.cdc.gov/vaccines/adults/vpd.html. Thousands of adults in the U.S. die each year and/or suffer needless pain due to vaccine preventable diseases. (e.g., flu, pneumonia, shingles, hepatitis, etc.) causing avoidable additional costs for an already overstrained health care delivery system. Lack of access to adult vaccinations also has disproportionate impact on minority populations, especially among non-whites.

Notably, the PND (p. 46) shows that many plans' "expanded benefits" include flu and shingles shots. While we are pleased that the plans have voluntarily decided to cover these services as an "extra," this is not an appropriate substitute for inclusion in the state plan Medicaid benefit package. Vaccinations must be part of adult core services routinely included in the preventive treatment regimen used by every plan and their providers. *We request that the waiver STCs require the Agency to work with CMS and other national experts to design and implement an adult vaccination program as a mandatory covered service.*

Quality Rating System

The new federal regulations provide that CMS, in consultation with stakeholders, develop a rating system aligning with the star rating used for Marketplace plans. States are required to use CMS' model unless the state creates an alternative system, approved by CMS, that provides "substantially comparable" information. 42 C.F.R. § 438.334. Of particular concern is that the new rating system include measures tailored to measure access and care quality relevant to unique Medicaid services (e.g., non-emergency transportation) and distinct Medicaid populations- children, pregnant women, seniors and persons with disabilities. Florida's demonstration provides a unique opportunity for the state to work with CMS on a "draft" national model and engage in a test "pilot."

We urge the Agency to promptly begin work with CMS to "pilot" a new quality rating system for Florida plans which are tailored to measure access and care quality relevant to the unique needs of Medicaid consumers.

Cultural Competency Plans (CCPs)

The most recent External Quality Review Organization (EQRO) report evaluated cultural competency plans and made recommendations. https://ahca.myflorida.com/medicaid/quality_mc/report_April_2016.shtml (pp. 17-18) Many of the recommendations point to the need for improving CCPs through better plan collection and analysis of membership demographic data, including race, ethnicity, language and the specific cultural needs of elders, persons with disabilities, homeless and LGBT communities.

We urge the Agency to continue its focused oversight of these CCP plans and their implementation. This is a critical step towards addressing health disparities within the Medicaid population. Also, further study is needed to determine whether the improved CCP plans are actually having a positive impact on health care outcomes for distinct historically underserved groups.

Implementation of New Appeals System

AHCA will be implementing two significant changes in the appeals process. For the first time, Medicaid enrollees will be required to exhaust their plan appeals process before they can pursue a Medicaid fair hearing when their services are denied, suspended, reduced or terminated. In addition, AHCA will be taking over from the Department of Children & Families ("DCF") administration of the fair hearing process.

We appreciate that the Agency intends to initiate an outreach campaign to inform Medicaid recipients of these changes. *We urge the Agency to do focused monitoring on the impact these changes are having on recipients.* This information will be absolutely critical to ensuring that recipients are able to fully access their appeal rights (including the right to continued services pending an appeal). Of particular concern is ensuring that plan customer service departments are fully educated and equipped to respond to appeal requests, that plans successfully resolve consumer complaints on a timely basis, and when complaints are not resolved, proper notices and information is provided to recipients on how to pursue a fair hearing.

Education on Consumer Protections

While there are some excellent consumer protections included in the Agency's contract, the reality is that they are buried in a 200+ page contract. Not surprisingly most Medicaid recipients are unaware of these protections pertaining to network adequacy, time/distance standards, continuity of care, disenrollment and appeal rights when services are denied, reduced terminated or suspended.

We urge the Agency to develop and pursue an outreach campaign on Medicaid managed care consumer protections, including education of families about EPSDT benefits and how to access them. It is recommended that this include consultation with community groups and the MCAC, enhanced coordination and partnerships with community organizations and development and implementation of strategies for targeting underserved and hard to reach populations.

Proactive & Focused Monitoring

While information gleaned from the complaint hub is an important component for effective Agency monitoring, it is insufficient by itself to paint the full picture of difficulties consumers face accessing services through managed care. Many consumers are unaware of the complaint hub and/or how to access it, particularly those who are not computer savvy.

We recommend more use of "proactive" monitoring tools, such as secret shoppers to test network adequacy for services such behavioral health and dental care and mining service denial data to identify barriers to access trends. Additionally, we recommend the use of "stratified" consumer satisfaction surveys and performance measures focusing on persons with chronic and complex medical conditions (e.g., SSI recipients, high utilizers of emergency room care and traditionally underserved populations).

Also as noted above, *we recommend focused monitoring, audits and data analysis relating to implementation of the new appeals process, delivery of cultural competent services and care coordination for persons with special needs.* An ongoing concern is whether the Agency has sufficient resources to effectively oversee and manage this multi-billion program. As Florida's Medicaid managed care program has expanded, AHCA staff resources have not kept up with the new demands of the program. Sufficient Agency capacity to oversee this program is key to improving beneficiary access, better health outcomes and the overall success of the program.

Uncompensated Care Pool

The waiver extension proposal does not include a request to extend the LIP program. However, we understand that the Agency and hospital providers are exploring other ways to draw down federal funds to supplement hospital payments.

While we support the hospitals' request for supplemental funding, we wholeheartedly concur with CMS' position that these funds are no substitute for providing coverage to the uninsured. There are over 500,000 low income uninsured Floridians who have fallen into the Medicaid coverage gap for nearly three years.

If the state decides to include a supplemental hospital funding program in its waiver extension request, we urge the inclusion of a waiver STC that requires an independent study of charity care provided around the state (as recommended by the hospital associations) and a related analysis of the impact on persons who remain uncovered due to the coverage gap and the impact on state and local economies.

Conclusion

We appreciate this opportunity to comment on the proposed waiver renewal request and look forward to continuing dialogue with the Agency to improve health access and quality for Florida's Medicaid recipients. Please let us know if you have questions or need additional information.

Sincerely,

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Sent Electronically

November 10, 2016

Beth Kidder
Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32301

Re: Florida's Medicaid 1115 Managed Care Waiver (Project Number 11-W-002064)

Dear Deputy Secretary Kidder:

The Florida Hospital Association (FHA), on behalf of over 200 member hospitals and health systems, appreciates the opportunity to comment on the Agency for Health Care Administration's (AHCA's) 1115 Managed Care Waiver Draft Proposal (Project Number 11-W-002064).

FHA views the Waiver renewal as an opportunity to move toward a more efficient, value-driven approach to care delivery. It is a path to modernize the health care system for our low-income patients and stabilize critical hospital financing. In preparation for the Waiver renewal, FHA established a task force comprised of hospital leaders throughout the state to develop recommendations for consideration.

Three key steps are integral to the FHA Medicaid Waiver Task Force's recommendations:
first, redesign how quality health care is delivered; next, remodel how quality health care is covered; and finally, realign how quality and efficient health care is assured.

Redesign How Health Care is Delivered

Redesigning how care is delivered should begin with reducing inappropriate emergency department visits and preventing avoidable hospital readmissions. These two areas provide the greatest opportunity to improve health outcomes for many Floridians, while significantly reducing costs. From 2009-2014, emergency department visits that resulted from mental health conditions and substance abuse steadily increased. And, in 2014, mental health and substance abuse disorders were the third most common diagnoses for ED visits among adults[1]. In addition, the Task Force analyzed Community Needs Health Assessments by Medicaid region, discharge and emergency department (ED) data to better understand utilization drivers. Resoundingly, mental health and substance abuse disorders and lack of access to primary care were identified in nearly every region.

Based on these findings, FHA recommends that the Medicaid Waiver proposal include delivery system transformation initiatives that support partnerships between hospitals and community-based partners to improve the way care is delivered. Through provider-led transformation initiatives, hospitals and community-based partners could work to reduce avoidable re-admissions and prevent unnecessary ED visits. The initiatives would focus on improving care transitions, addressing complex patients with high social needs, strengthening community-based care and increasing capacity to address mental health and substance abuse disorders through greater use of community-based organizations. By utilizing allowable payment innovations in the 1115 Medicaid Waiver, Florida can implement these initiatives without the need for new, state general revenue.

Strong, reliable data will be critical to any effort to transform care delivery and increase the use of value-based payment mechanisms. In particular, hospitals and other providers will require data to analyze readmissions and ED

[1] Based on data from the Federal Agency for Healthcare Research and Quality Healthcare Cost and Utilization Project (HCUP) submitted by the Florida Agency for Health Care Administration.

usage over time and how they are correlated with care provided in the community, including data not directly available from hospital claims systems.

Accordingly, we recommend that the Waiver include provisions to strengthen the quality and availability of data on Medicaid care patterns and expenditures across community and hospital settings.

In pursuing a redesign of how care is delivered, FHA recommends that AHCA propose sustainable funding sources for Florida's Medicaid program that maximize existing state resources and restructure available funding sources. The state should seek Waiver authority from the Centers for Medicare & Medicaid Services (CMS) to secure federal Medicaid matching funds for these existing state and locally funded programs (CMS refers to them as "designated state health programs"). Florida could leverage the considerable funding already provided for low-income individuals to access services to address mental health and substance abuse disorders. CMS has approved the use of designated state health program funding in other states, including, but not limited to, Alabama, Massachusetts, New Hampshire, New York and Oregon.

Remodel How Quality Health Care is Covered

Remodeling how quality health care is covered is essential to establishing a more efficient, value-driven approach to provide care. FHA believes it is imperative that the Waiver includes a Florida-specific mechanism to extend health care coverage to low-income, uninsured people. This will provide care to the state's most vulnerable residents, reduce the impact of the uninsured on the state budget and allow Florida to establish models appropriate for our unique delivery system and state approach to promoting timely, appropriate care that is less costly.

Even if Florida implements a state-specific approach to providing additional coverage for the uninsured, it is critical to highlight that our state, much like Texas and California, will continue to be home to high numbers of transient workers and immigrants who do not qualify for coverage. CMS has allowed the continuation of uncompensated care pools in those states as acknowledgement of this fact. FHA believes the state should seek the reauthorization for Florida's uncompensated care pool, referred to as the Low Income Pool, as it ensures access to care for our state's uninsured residents. Florida's uncompensated care pool should be sized appropriately given the state's level of uncompensated care and the low amount of Disproportional Share Hospital funding.

Consistent with studies recently conducted in Texas and California, FHA recommends the state seek an independent analysis to determine accurate uncompensated care costs remaining in Florida since the Affordable Care Act's implementation.

Realign How Quality Health Care is Assured

Given the waiver renewal is an opportunity to improve care and lower costs, FHA recommends a strong focus on aligning payments with quality outcomes in the Waiver. This recommendation is based on the concept of value-based payments in which providers are accountable for the care delivered.

We also recommend including provisions in the Waiver renewal to increase operational efficiency, streamline administrative procedures, increase the transparency of Florida's managed care program's oversight, provide resources to prepare providers to participate in value-based payments, and establish new incentives for hospitals, in partnership with community partners, to improve care across the continuum.

With nearly all of Florida's Medicaid beneficiaries enrolled in managed care, delivery system improvements should begin there. Since the Waiver is our vehicle for authorizing and operating Medicaid managed care in Florida, FHA recommends that the renewal include provisions to strengthen our managed care system.

First, we recommend that the Waiver include stronger network adequacy requirements related to post-acute care. Florida hospitals have experienced significant delays in obtaining authorization, or placement, for post-acute care services. This results in patients remaining in the hospital beyond what is medically necessary. To address this

issue, FHA recommends that the state include managed care plans subcontractors in each network adequacy review to ensure all subcontractors are able to provide services to multiple plans in a region as proposed.

FHA also recommends the state set uniform administrative procedure and provider requirement policies. This standardization should also apply to managed care plan authorizations and coverage of services to ensure that each beneficiary's coverage is consistent throughout the program. In the current system, Medicaid coverage can vary by each individual health plan's policy (e.g., the implementation of a new standard of "prudent layperson" for determining emergent vs. non-emergent care).

Finally, transparency is a key component to a successful Medicaid program. Through robust health plan data collection and public reporting, the state and providers would be able to identify which health plans are implementing successful programs that could be replicated in other regions of the state. Additional transparency would also help providers identify frequent ED users and determine the causes for inappropriate utilization, such as inadequate primary care networks or other social determinates.

As Florida's hospitals continue our longstanding commitment to providing high-quality care to all patients, we would like to thank AHCA for proposing to extend the 1115 Waiver. The 1115 Waiver provides the state with the maximum flexibility for improving Florida's Medicaid program through innovations in care delivery and payment reform. Florida's hospitals, in partnership with the state and CMS, look forward to working together to establish meaningful quality improvement and payment reforms outlined.

Again, we thank you again for the opportunity to comment on your proposal. The FHA is committed to working with AHCA to help ensure a successful renewal of the 1115 Waiver.

Sincerely,

Crystal Stickle
Vice President of Government Affairs
Florida Hospital Association

Eisai Inc.

November 10, 2016

Ms. Beth Kidder
Deputy Secretary, Medicaid
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

Submitted Via Email: FLMedicaidWaivers@ahca.myflorida.com

Re: Florida Section 1115 Medicaid Waiver; Proposal to Amend List of Covered Outpatient Prescription Drugs

Dear Deputy Secretary Senior:

I am writing to you on behalf of Eisai Inc. (Eisai), to formally submit comments to the proposed Florida Section 1115 Waiver extension and amendments. Eisai believes the Agency for Health Care Administration (AHCA) should include in this Waiver, an amendment to the state plan to modify the list of covered outpatient prescription drugs to include anti-obesity drugs as permitted by §1927(d)(2) of the Social Security Act. This will make an investment in the health of Floridians and can realize savings in Florida's health care expenditures in the future. According to the Robert Woods Johnson Foundation, a 5% reduction in the average Body Mass Index (BMI) can realize $12 billion dollar savings in health care costs in 10 years.[1]

At Eisai Inc., *human health care* is our goal. We give our first thoughts to patients and their families, and helping to increase the benefits health care provides. As the U.S. pharmaceutical subsidiary of Tokyo-based Eisai Co., Ltd., we have a passionate commitment to patient care that is the driving force behind our efforts to help address unmet medical needs. We are a fully integrated pharmaceutical business with discovery, clinical, manufacturing and marketing capabilities. Our key areas of commercial focus include oncology and specialty care (Alzheimer's disease, epilepsy and metabolic disorders). To learn more about Eisai Inc., please visit us at www.eisai.com/US.

[1] Trust for America's Health and Robert Woods Johnson Foundation, "F as in Fat" (2012). http://healthamericans.org/assets/files/TFAH2012FasinFatFnlRv.pdf

With an incidence rate of 36.5%[2], adult Obesity is an epidemic in the United States, as well as in Florida an obesity incidence rate of approximately 26.8%.[3] Health care spending for obese adults exceeded spending for adults of normal weight by approximately 38% in 2007 and total health care costs related to obesity are estimated to be $147 billion per year, according to 2008 data.[4] Eisai believes physicians should have the ability to treat all patients, particularly the Medicaid population, with the entire continuum of care available to treat obesity, including pharmacotherapy.

Unfortunately, Obesity affects the poor and indigent more than it affects those that are wealthier. "More than 33% of adults who earn less than $15,000 per year are obese compared with 24.6% of those that earned at least $50,000."[5] If policymakers want to make a true impact on the incidence of obesity, it is imperative that they integrate treatments from the entire continuum of care, including anti-obesity drugs whenever medically indicated.

Section 1927(d)(2) provides states the flexibility to cover weight-loss drugs. Several Florida managed Medicaid plans already cover anti-obesity drugs when medically necessary, but drugs in this class are not widely available throughout all plans. Eisai believes by removing this restriction AHCA will guarantee equitable access to these drugs amongst managed Medicaid plans and within fee-for-service Medicaid.

Treatment and Management of Obesity as a Chronic Illness

Obesity is a chronic disease and should be treated as such. In 2013, the American Medical Association voted to designate obesity as a chronic disease. After the AMA designation, the CMS ICD-10 codes now include a code for obesity. It is now recognized as a disease by the government.

Section 1927 was written long before the FDA approved several new innovative pharmaceuticals to treat obesity. As such, treatment guidelines from several nationally recognized provider organizations are far ahead of the law, and all recommend use of pharmacotherapy to treat obesity. These groups are:

- The Endocrine Society;
- The American Association of Clinical Endocrinologists;
- The American Society of Bariatric Physicians;

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[2] Trust for America's Health and Robert Woods Johnson Foundation, "The State of Obesity 2016: Better Policies For A Healthier America," 2016.
[3] Ibid.
[4] Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual medical spending attributable to obesity: payer-specific estimates. Health Aff. 2009;28(5):w822-831.
[5] Trust for America's Health and Robert Woods Johnson Foundation, "The State of Obesity 2015: Better Policies For A Healthier America," 2015.

- The Academy of Nutrition and Dietetics and the American Society of Metabolic and Bariatric Surgery; and
- The Obesity Society.

Improvements in Health and Health Care Expenditure Savings

A new study recently published in the June 2016 edition of the Journal of the American Medical Association (JAMA) reviewed the five medications that have been approved by the FDA and demonstrated efficacy. Of the 29,018 patients that were included in 28 randomized clinical trials for the 5 drugs reviewed, patients achieved at least a 5% weight loss at 52 weeks[6] on every drug. As noted earlier, if the State of Florida reduced the average BMI in the state by 5%, the state would reduce total health care costs by $12 billion in 10 years. In 20 years, that savings would grow to $14.729 billion.[7] The savings linked to obesity is derived from fewer people needing hospitalizations or medical treatment for additional conditions associated with obesity. Obesity is linked to a variety of chronic illnesses, including diabetes, heart disease, stroke, sleep apnea and cancer. Research shows that even modest weight loss, 5% or more, can produce meaningful health benefits such as improvements in blood pressure, cholesterol, and blood sugar levels.[8]

Thank you for the opportunity to comment on waiver extension request. If you or your staff have any questions, or would like to discuss Eisai's comments further please contact me at timothy_clark@eisai.com or at 202-437-7358.

Sincerely,

Tim Clark
Senior Director, Government Affairs, Policy and Corporate Advocacy

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[6] Rohan, Khera, MD et al., "Association of Pharmacological Treatments for Obesity with Weight Loss and Adverse Events: A Systematic Review and Meta-analysis. *JAMA*, 2016. (www.jama.com)

[7] Trust for America's Health and Robert Woods Johnson Foundation, "F as in Fat" (2012). http://healthamericans.org/assets/files/TFAH2012FasinFatFnlRv.pdf

[8] Allison DB, Downey M, Atkinson RL, et al. Obesity as a disease: a white paper on evidence and arguments commissioned by the Council of the Obesity Society. Obesity. 2008;16:1161-1177.

November 10, 2016

Beth Kidder
Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32301

Re: Florida's Medicaid 1115 Managed Care Waiver (Project Number 11-W-002064)

Dear Deputy Secretary Kidder:

Tampa General Hospital (TGH) appreciates the opportunity to be able to comment on AHCA's request to extend Florida Medicaid's 1115 Managed Medical Assistance Waiver through June 30, 2020. TGH is a private not-for-profit hospital and one of the most comprehensive medical facilities in West Central Florida serving a dozen counties with a population in excess of 4 million. As one of the largest hospitals in Florida, TGH is licensed for 1,011 beds, and with approximately 6,500 employees, is one of Tampa Bay's largest employers. TGH is the primary teaching hospital for the USF Health Morsani College of Medicine and trains over 300 residents which are assigned to TGH for specialty training in areas ranging from general internal medicine to neurosurgery. TGH is the area's only level 1 trauma center, one of just four burn centers in Florida, and home to one of the largest organ transplant centers in the country. Specific to our comments regarding the Medicaid waiver, TGH is among the top four Florida providers of inpatient hospital services to Medicaid eligible beneficiaries. In addition, TGH is one of the largest providers in the State for inpatient hospital services to uninsured Floridians.

In the previous State Fiscal Year ending June 30, 2016, Hillsborough County hospitals received approximately **$52 million** in Low Income Pool (or LIP) funding through the State's current Medicaid waiver. Of this amount, TGH received approximately **$32 million** in LIP funding. This supplemental federal funding, which the LIP program provides, is critical to hospitals, such as TGH, in helping to offset the costs of providing quality care to Florida's uninsured population which most often represent the sickest and most vulnerable patients in our community.

While we recognize that the federal government does wish to phase out the historic methodology upon which the LIP program is based, TGH believes that AHCA should aggressively seek continuation of a LIP-type program similar to the more recent CMS-approved methodology and should seek additional charity care replacement funding from CMS to make up for the recent reductions to the LIP pool. In order to do this in a way that promotes a more efficient, value-driven approach to care delivery, three key steps are integral; a redesign of care delivery, remodel how quality health care is covered, and realign how quality and efficient care is assured.

First, a redesign of how health care is delivered is integral. TGH recognizes the two areas with the greatest opportunity to improve health outcomes while reducing costs are emergency room (ER) visits and readmissions. TGH supports the Florida Hospital Association's (FHA's) Medicaid Waiver Task Force recommendations to include delivery system transformation initiatives that support partnerships

between hospitals and community based partners. By utilizing allowable payment innovations in the 1115 Medicaid Waiver, Florida can implement these initiatives without new, State general revenue. The State should seek Waiver authority from the Centers for Medicare & Medicaid Services (CMS) to secure federal Medicaid matching funds for these existing state and locally funded programs (CMS refers to them as "designated state health programs"). Florida could leverage the considerable funding already provided for low-income individuals to access services such as mental health and substance abuse. CMS has approved the use of Designated State Health Program funding in other states, including, but not limited to, Massachusetts, New York and Oregon.

Second, the waiver renewal is an opportunity to remodel how quality health care is covered. Much like Texas and California, Florida maintains significant uninsured residents even with the Affordable Care Act implementation of additional coverage. These residents, immigrant and transient workers, are some of the state's most vulnerable individuals. CMS has recognized this and allowed the continuation of uncompensated care pools in Texas and California. Consistent with studies recently conducted in those states, TGH supports FHA's recommendation that the state seek an independent analysis to determine accurate uncompensated care costs remaining in Florida since the ACA's implementation in order to appropriately size the state's uncompensated care funding.

Finally, the waiver renewal should include a strong focus on aligning payment with quality outcomes. TGH supports FHA's recommendations to set uniform administrative procedures and provider requirement policies applicable to managed care plan authorizations and coverage of services to ensure that beneficiaries' coverage is consistent throughout the program. Medicaid coverage currently can vary by each individual health plan's policy which results in significant delays in obtaining authorizations and plans' ability to ensure all subcontractors are able to provide services in each region as proposed.

We thank you for allowing TGH the opportunity to provide these brief comments on this critical issue. TGH is committed to working with AHCA to help ensure a successful renewal of the 1115 Waiver.

Sincerely,

Steve Short
EVP/Chief Financial Officer
Tampa General Hospital

Disability Rights
FLORIDA

November 10, 2016

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

Re: Comments on 1115 MMA Waiver Extension

To whom it may concern,

This letter constitutes Disability Rights Florida's official written comments regarding the 1115 MMA Waiver Extension Request.

I. Purpose, Goals, and Objectives

B. Goals and Objectives

(1) Promote an integrated health care delivery model that incentivizes quality and efficiency

a. Disability Rights Florida has identified a number of issues with both the quality and efficiency of services provided to consumers:

i. Transportation: Consumers have reported issues with utilizing transportation for medical appointments. Consumers have missed their scheduled medical appointments due to transportation providers arriving late or not at all. Consumers have also been left unattended or stranded at a physician's office or in the community when transportation providers arrive late or not at all after the consumers' medical appointment is completed.

ii. Accessing medically necessary services: Consumers reported that they have had issues with accessing medically necessary services. Consumers have expressed difficulty in obtaining referrals to specialists or finding a specialist who is accepting new patients in their health plans. Consumers have also experienced issues obtaining consumable medical supplies. Consumers not only have issues locating a provider for their consumable medical supplies, but also have issues with the available providers not delivering the supplies in a timely manner or delivering the wrong supplies.

iii. Availability and Accessibility of Benefit Information: Consumers have reported issues with accessing MMA plan Member Handbooks online. Additionally, The MMA plan Member Handbooks provide inconsistent and inadequate information regarding the services available to consumers, especially consumers who are eligible to receive services through the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. The MMA Member Handbooks need to be reviewed and updated to more closely reflect the service information provided by the Agency for Health Care Administration Service Handbooks and Coverage Policies.

(2) Enhance access to primary and preventive care through robust provider networks

2473 Care Drive, Suite 200 • Tallahassee, FL 32308
850.488.9071 • Toll Free: 800.342.0823 • Fax: 850.488.8640 • TDD: 800.346.4127
www.DisabilityRightsFlorida.org • Florida's Protection and Advocacy System

a. Disability Rights Florida has not seen evidence that a robust provider network is available to consumers enrolled in MMA plans. Consumers have had issues locating providers and in many cases, are only able to utilize one provider for a specific service. Additionally, providers have reported issues with contracting with the MMA plan contracted companies causing the pool of available providers to diminish.

Best Regards,

Digitally signed: *Rachel Siegel-McLaughlin*

Rachel Siegel-McLaughlin, Esq.
Staff Attorney, Disability Rights Florida

FLORIDA LEGAL SERVICES, INC.

MIAMI ADVOCACY OFFICE

3000 BISCAYNE BLVD., STE. 102, MIAMI, FL 33173 - PHONE: 305.573.0092 - FAX: 305.328.6086

ERIC SODHI
PRESIDENT

CHRISTOPHER M. JONES
EXECUTIVE DIRECTOR

November 10, 2016

VIA ELECTRONIC SUBMISSION FLMedicaidWaivers@ahca.myflorida.com

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

Re: Florida Managed Medical Assistance Program 1115 Research and Demonstration Waiver 3 year extension request comments

Dear Sir/Madam:

Florida Legal Services (FLS) is a statewide public interest law firm that advocates on behalf of low-income individuals and families on a range of health-related matters, including Medicaid. We appreciate the opportunity to comment on the MMA Waiver Extension Request. This comment concerns the need for ongoing and comprehensive secret shopper surveys in order to ensure that MCOs maintain network standards, as well as maintain accurate provider directories.

In 2015, FLS conducted a thorough survey of the network of psychiatry providers who were listed in their respective plan's provider directories as serving Miami Medicaid beneficiaries. The survey demonstrated an alarming level of contract violations. For example, while 364 psychiatrists were listed across the 14 provider directories, only 193 of those were reachable. The other 171 were unreachable because the phone number provided was wrong, out of service, or there was no answer. Another point of concern was the low percentage of providers accepting new Medicaid patients, with even the best of the plans limited to 33% of its reachable providers. Finally, even when providers were reachable and accepting new patients, the average wait time was over 6 weeks for an appointment.

Our findings were shared with AHCA's Deputy Secretary of Medicaid, (attached to these comments) on September 28, 2015, and the Agency promptly responded with its own "secret-shopper." Liquidated damages were assessed to all plans in Miami-Dade County as a result of the inaccurate provider directories confirmed by the Agency's own survey. A "corrective action plan" was also required from all of the managed care plans "to address steps

and timeframes to resolve this contract violation and ensure the violation doesn't occur in the future." The Agency's survey did demonstrate some improvement in regard to the percentage of reachable providers and those accepting new patients, meanwhile confirming that network accuracy and adequacy problems remain. The Agency noted in its survey that, "Wait times varied, ranging from same-day appointments to an appointment in 8 weeks or longer." Although some of the metrics showed improvements, the results, as noted by the Agency, were inconclusive.

While FLS commends the Agency for its responsiveness to the inaccuracy issue,neither the liquidated damages nor the corrective action plan addresses continued concern over *inadequate* networks or inaccurate directories. .

Recommendation: We recommend that the Agency identify funding for, and engage in regular ongoing secret shopper surveys to ensure that plans are in compliance with the provider network standards set out in the Model Contract, particularly those provisions requiring an adequate network of providers, as well as the time and distance standards the plans must comply with to maintain such a network. In addition to reviewing the network as it currently exists, we also request that the Agency consider implementing a more robust monitoring system that would allow real-time updates when networks fall below these standards with a plan to promptly correct the deficiency.

Thank you for your consideration of these comments and recommendations.

Katy Huddlestun, J.D.
katy@floridalegal.org

/encl.

Jonathan M. Ellen, M.D.
President, CEO and Physician-in-Chief
Johns Hopkins All Children's Hospital
Vice Dean and Professor of Pediatrics
Johns Hopkins University School of Medicine

Office of the President & Vice Dean
501 Sixth Avenue South
Box 2709
St. Petersburg, FL 33701
727-767-6873
jellen@jhmi.edu

November 8, 2016

Beth Kidder
Interim Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32301

Re: Florida's Medicaid 1115 Managed Care Waiver (Project Number 11-W-002064)

Dear Deputy Secretary Kidder:

Thank you to the Agency for Healthcare Administration (AHCA) for your leadership and hard work throughout implementation and renewal of Florida's Medicaid 1115 Managed Care Waiver. We appreciate you giving us the opportunity to provide comments from the unique perspective of a specialty licensed children's hospital in Florida.

Johns Hopkins All Children's Hospital, located in St. Petersburg, Florida, is one of only three specialty licensed children's hospitals in the State. Our mission is completely dedicated to the health and well-being of children, and our pediatric specialists are focused on treating Florida's sickest children. As the State's highest Medicaid provider, with approximately 70 percent of our patients benefitting from Medicaid, we are devoted to providing these vital pediatric services despite the fact that Medicaid reimbursements often do not cover the cost of our care.

Since implementation of Florida's Medicaid Managed Care program, we have experienced many of the managed care plans utilizing narrow networks for pediatric services. While this may be an adequate solution for adult patients, many of these providers are not pediatric trained. This results in reduced quality of care, as well as access to care issues as patients and families struggles to find transportation to multiple appointments in different locations. Specialty licensed children's hospitals provide access to pediatric specialists in one location, allowing for improved access and quality of care, and therefore cost savings for the Medicaid program.

Of additional concern to us are the significant time delays we have experienced for pediatric respiratory, skilled nursing, and home health. Due to reimbursement issues within the managed care program, there are limited vendors available with pediatric expertise, which affects our ability to consistently provide a safe transition from hospital to home. If we are able to find vendor, there is often a significant time lapse due to the lengthy and burdensome process of obtaining prior authorizations. The inconsistent policies and procedures among health plans are cumbersome and difficult for providers to navigate, resulting in longer hospital stays for our patients. We recommend a single streamlined process for obtaining authorizations and

standard criteria to determine utilization management, in order to reduce length of stay, improve the transition to home, and limit readmissions for our patients.

Johns Hopkins All Children's is dedicated to providing care to Florida's children, and as advocates for this population, we highly advise AHCA to address the aforementioned issues preventing access to high-quality pediatric care as you seek to renew the Medicaid 1115 waiver. We look forward to continuing to work with AHCA on opportunities to improve quality of care and access for children to the pediatric specialty care they need. Thank you for your time and consideration.

Sincerely,

Jonathan M. Ellen, M.D.
President and Vice Dean
Johns Hopkins All Children's Hospital

From: Mary Rainer [mailto:birthblossoms@gmail.com]
Sent: Friday, October 14, 2016 10:10 PM
To: FLMedicaidWaivers <FLMedicaidWaivers@ahca.myflorida.com>
Subject: 1115 MMA Waiver Extension Request

I think the mMA program is HORRIBLE putting the management of medical benefits in the hands of private companies- I am speaking as a dedicated midwife who has seen medical care provider after provider close their doors to women NEEDING care, pregnant or otherwise, new babies :(being forced to send high risk patients out of town for care because noone left in our town accepts their medicaid because they are not getting paid- it is a TRAVESTY
Please please go back to regular medicaid.
Mary Rainer
fort Pierce, Florida