Questions on Florida MediPass Renewal

Programmatic Questions – Sections A-G

1. General. Healthy literacy interventions are identified as additional services under Section 1915(b)(3) in section A.II.g. Please provide the following additional information on the proposed program:
    - scope of services, duration, whether services will be available Statewide
    - whether these programs are supported by the Pfizer supplemental agreement
    - assurances that state matching funds are provided through the general revenue funds and are not otherwise prohibited
    - general operation and management of the program
    - beneficiaries to whom program will be targeted
    - whether the effort will be multi-lingual

2. A.III.b. p. 17, Lock-in. For Healthy Start, enrollees must be given 90 days (not the 60 days noted in the waiver) to change PCPs upon initial enrollment.

3. A.III.d., p. 44, Child Health Check-Ups. Please provide the EPSDT screening rate by HMO, PCCM, PSN, and CMS program, for the most recent period available.

Clarifications and Corrections – Sections A-G

4. A.II.g., page 7 - Statutory Authority.
    a) The CMS Capitated Network was approved under 1915(b)(4) authority to allow for selective contracting. However, the CMS Network is listed under other sections stating that they will operate under 1915(a) authority. Please clarify if the State will contract with all qualified providers under the capitated program. If not, please include the CMS Capitated Network under 1915(b)(4).

    b) DMOs also need to be added to 1915(b)(4) authority.

    c) Will the State selectively contract with EPOs or Health Literacy Providers? If so, 1915(b)(4) authority should be requested for these programs.

    d) Please include HMOs in the 1915(a) authority identified in "Other Statutes."

5. A.II.i, p. 8 – Geographic areas. Please list where DMOs are available.

6. A.III.b., p.15 – Mandatory assignment. Please provide the level of detail provides in the previous waiver's Appendix F, i.e. whether assignments will be distributed

evenly among programs, or will be weighted towards a given program (and if so, how).

7. A.III.b., p. 18 – Disenrollments. Please clarify that the process for PSNs, MCO, and EPOs to request disenrollment of an enrollee also applies to PCCM providers.

8. Enrollment – general. Does the state still provide for automatic re-enrollment with the same provider if a beneficiary loses Medicaid eligibility for up to 60 days (as was done in the previous waiver period)? If so, please stipulate.

Cost Effectiveness Questions – Section H

9. Page 76, first paragraph. Please provide additional details regarding data extraction method using the program for setting capitation rates. Specifically:

   a) Were data obtained from the MMIS system?
   b) Provide information regarding what adjustments, if any, were made to the data to obtain the PMPM. Please address specifically the following whether and how the following adjustments were made:
      - smoothing data
      - pharmacy rebates
      - supplemental rebates
      - programmatic changes
      - recently approved UPL SPAs for hospital services

10. Page 76-77, TANF/SSI eligibles. Please identify the table that represents the member months for TANF and SSI eligible identified in this section.

11. Page 76-77, TANF/SSI eligibles. Clarify if member months for individuals eligible for voluntary enrollment are included. If so, explain how selection bias will be addressed in the with waiver calculations.

12. Page 78. Please clarify the statement at the top of the page which reads as follows:

    > "During the last two years rate increases were substantially higher for MediPass eligibles not yet enrolled in managed care. Thus, to determine the rate of costs without the waiver programs, the difference in the compound trend was used for the look-back. Costs savings for years prior to the look-back were not revised from the previous submission."

13. Page 78, HMO Costs. HMO capitation rates are based on historical fee-for-service expenditures for the entire Medicaid population, adjusted forward to the contract period. Please provide clarification on the following statement:

> "HMO costs without the PCCM waiver would be higher as the rates are built off the combined fee-for-service and MediPass rates. It is assumed that without waiver costs would be higher by the percentage saved by MediPass."

On page 79, differences in the profile of HMO enrollees is provided. Based on the information, please reconcile these two statements. The latter appears to indicate that there is adverse selection in the MediPass and fee-for-service program. Since HMO rates are based on the MediPass and the fee-for-service program, it would appear logical costs attributable to HMOs could be less without the MediPass waiver. Please explain how savings from MediPass are reflected in the HMO rates.

14. Page 79, EPO Costs. As indicated in question 12, please describe how the rates will be adjusted to address the potential for adverse selection.

15. Page 79, Case Months without the Waiver. Please clarify the actual case months includes only MediPass eligibles, MediPass mandatorily enrolled individuals, or both MediPass manaditorily enrolled individuals and MediPass voluntarily enrolled individuals. Do case months include individuals enrolled in the fee-for-service program?

16. Page 80, Table A. Please explain how the case months provided in Table A are used to determine PMPM in the Tables provided in the Appendices.

17. Page 80, Case Months with Waiver. This section states that changes in case months due to changes in the auto assignment process or the economy, are not reflected in the Table A case months as they will not affect the PMPM. We request that the changes in case months due to such changes be approximated to obtain an accurate projection of with waiver expenditures. While we agree that the PMPM will not be affected and that if affected would be difficult to prospectively quantify, the effect on total expenditure should be demonstrated since it will affect cost savings. Due to the significant amount of additional services provided with 1915(b)(3) savings, the State must demonstrate that total savings from State plan services only are sufficient to support the additional services. This can only be demonstrated by properly accounting for the potential reduction in savings under MediPass in an effort to equalize enrollment in MediPass and HMOs.

18. Page 81, Table C. Please adjust projected case months to reflect changes in the mandatory assignment process or the economy as indicated above.

19. Page 81, Cost under the Waiver. Please clarify the base year used to project expenditures to obtain actual costs for Medicaid eligibles for FY 2000-2001. Please clarify whether data are presented for the calendar, State fiscal or Federal fiscal year.

20. Page 81, Cost under the Waiver. As specified in Term and Condition # 3 of approval letter, effects (or savings) attributable to DM or PSN, should not be included in the aggregate PMPM. Instead, the costs and savings of additional services must be broken out and reflected independently, then added to costs and savings.

21. Page 81, Cost under the Waiver. We encourage you to include prospective cost savings due to DM and PSN in the savings calculation as well as saving obtainable from other value added programs.

22. Page 81, Cost under the Waiver. Please clarify that administrative costs and other program costs necessary for operating the PSN, DM, and Healthy Start are reported in the Table 2 historical assessment as additional costs.

23. Page 81, Cost under Waiver. Please provide additional information regarding assumptions made with respect to proposed savings under the waiver. Provide any evidence that supports your assumptions.

24. Page 84, Waiver Costs not Included in PMPM Costs. Please include costs for the following:

    - data management
    - enrollment broker
    - consultants
    - independent assessments
    - medical on-site review
    - dedicated state staff and benefits
    - MMIS edits
    - additional expenses.

25. Page 86, Cost Effectiveness Summary. Please provide PMPM expenditures for all services, PMPM expenditures for 1915(b)(3) services, and PMPM savings for each waiver year.

26. Table 3. Please explain why a blended "overall" PMPM is provided.

27. Tables 4-8. Please provide additional support for these expenditure breakdowns.

28. General – Healthy Start. Are savings being projected for this program for the renewal period, or are projections limited to funding new costs through 1915(b)(3) authority?

29. General – FFS. Please clarify what this is comprised of. It is only the case months and expenditures for non-managed care eligibles? Does it include the pre-enrollment months of managed care eligibles?