Centers for Medicare & Medicaid Services
Office of Information Services
Information Services Design & Development Group
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Section 1115 Demonstration Program

Florida MEDS AD Section 1115 Demonstration CMS11-W-00205/4 Renewal Request

For the Period January 1, 2014 through December 31, 2016

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Florida MEDS AD Section 1115 Demonstration CMS11-W-00205/4 Renewal Request

Section I - Program Description

Program Summary

The MEDS-AD Program Section 1115 demonstration CMS 11-W-00205/4 provides Medicaid eligibility for individuals who are disabled or age 65 or over, and who are also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services; and whose incomes do not exceed 88 percent of the federal poverty level and whose assets do not exceed $5,000 for individuals or $6,000 for couples. Individuals enrolled in the demonstration receive State plan benefits and may also receive pharmacy case management services. Applicable Medicaid State plan co-payments apply and services are delivered through the same delivery system available to State plan enrollees.

Rationale and Hypothesis

The intent is to demonstrate that access to health care services and voluntary pharmacy case reviews result in measurably improved outcomes. The continued coverage, as well as the High-Intensity Pharmacy Case Management program, will be funded through savings obtained by avoiding institutional costs that would otherwise occur in the next five years had these vulnerable individuals not had access to prescribed drugs and other medical services.

In 2005, State legislation (Chapter 2005-60, Laws of Florida) directed the State to discontinue coverage of these individuals (an optional Medicaid eligibility group) under the Medicaid State plan. However, concerned that this population was at risk for costly adverse events, including institutional placement, in the absence of pharmacy and medical services, the same legislation directed the State to seek a section 1115 demonstration to provide benefits to a subset of the individuals in this eligibility group. With CMS approval, the Demonstration began operating in January 2006.

The Demonstration was predicated on the assumption that continued access to medical care, including home and community-based services and pharmacy management services, for this population, will delay deterioration in health status which drives hospitalization and/or institutionalization and result in improved patient perceptions of their health care services.

Historical Summary

The initial federal approval period for the MEDS-AD Program was January 1, 2006 through December 31, 2010. CMS approved an amendment permitting the State to receive FFP for data mining activities performed by the State's Medicaid Fraud Control Unit (MFCU) consistent with the

Memorandum of Understanding between the State and the Florida Office of the Attorney General which operates the MFCU, beginning August 1, 2010. Federal CMS approved renewal of the waiver for the period January 1, 2011 through December 31, 2013, and this renewal request would extend federal authority for the program from January 1, 2014 through December 31, 2016. The program has provided continued eligibility and services for the population, and has met budget neutrality requirements throughout the demonstration.

The process of providing pharmacy case reviews to waiver recipients who wish to participate has been refined and improved throughout the demonstration. Limitations in the original process were identified during the initial waiver period, and an improved process that includes active recipient input has been developed. Patient opinions of the quality of their health care for recipients who have chosen to participate in the case review program are measurably positive. Appendix A of this document contains the final evaluation report for the initial waiver period that ended December 31, 2010, and interim reports for the current waiver operating period.

Throughout operation of this demonstration, the State has met all requirements of the special Terms and Conditions, and the office of Medicaid Program Integrity and the MFCU have complied with the CMS approved Memorandum of Understanding concerning data mining activities. The State wishes to provide continued access to medical care, including home and community-based services and pharmacy management services, for this population, to delay deterioration in health status and result in improved patient perceptions and understanding of their health care services.

Statewide Eligibility Criteria for the Demonstration

Medicaid services for eligible individuals are authorized statewide through the MEDS AD Waiver in Florida Statutes as follows:

> "409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be eligible subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.
> (1) Subject to federal waiver approval, a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services. The agency shall seek federal authorization through a waiver to provide this coverage."

Timeframe for the Demonstration

The State seeks a renewal of this waiver authority for three years, from January 1, 2014 through December 31, 2016.

Impact of this Renewal on other Components of the State Medicaid and CHIP Programs

The renewal would not impact any other eligibility or service provisions of the State's Medicaid or CHIP programs. Renewal of the waiver would simply allow the State to maintain eligibility for this population, and all services would continue as provided under the State plan.

Section II – Demonstration Eligibility

Waiver Population

Expansion Populations

Eligibility Group Name	N/A	Income Level
Florida MEDS AD Waiver: a person who is age 65 or older or is determined to be disabled, whose income is at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations, and who is not eligible for Medicare or, if eligible for Medicare, is also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services.	(waiver request)	Between State plan eligibility income level and 88% FPL, with assets not more than $5,000 for an individual or $6,000 for a couple

Eligibility Standards and Methodologies

Under this renewal authority, the State will continue to use the applicable State plan standards and methodologies to determine eligibility.

Enrollment Limits

There is no cap on enrollment in this waiver; all individuals who meet the eligibility standard are provided Medicaid services.

Enrollment History, Current Enrollment and Projected Enrollment through Renewal Period

Please see the following chart for historical enrollment under this waiver for the past three waiver years, and projected enrollment under the waiver through the renewal period.

MEDS AD Waiver Enrollment History January 2010 through February 2013
Projected Enrollment* March 2013-December 2016

Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
31,147	32,023	33,169	33,612	34,384	34,702	34,932	35,452	36,119	36,382	36,199	35,927
Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
36,618	36,960	37,287	37,554	38,377	38,405	38,994	39,006	39,004	39,753	40,394	40,513
Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
41,231	42,297	42,620	42,888	42,541	42,464	42,564	42,387	42,823	42,635	42,064	41,924
Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
41,275	41,374	43,580	43,769	43,958	44,147	44,336	44,525	44,714	44,903	45,092	45,281
Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
45,640	45,999	46,358	46,717	47,076	47,435	47,794	48,153	48,512	48,871	49,230	49,589
Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
49,948	50,307	50,666	51,025	51,384	51,743	52,102	52,461	52,820	53,179	53,538	53,897
Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
54,256	54,615	54,974	55,333	55,692	56,051	56,410	56,769	57,128	57,487	57,846	58,205

*Source: Florida Social Services Estimating Conference, January 2013

Post-eligibility Treatment of Income for Long-Term Services and Supports

The State's current eligibility rule (Rule 65A-1.716, Florida Administrative Code, Income and Resource Criteria), which utilizes spousal impoverishment rules under section 1924, of the Act, states:

> (c) Spousal Impoverishment Standards.
> 1. State's Resource Allocation Standard. The amount of the couple's total countable resources which may be allocated to the community spouse is equal to the maximum allowed by 42 U.S.C. § 1396r-5.
> 2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
> 3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess shelter expenses to be included in the maximum income allowance: MMIA × 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.

After an individual satisfies all non-financial and financial eligibility criteria institutional care services, the department determines the amount of the individual's patient responsibility. This process is called "post eligibility treatment of income". Individuals residing in medical institutions shall have $35 of their monthly income protected for their personal need allowance.

The department applies the formula and policies in 42 U.S.C. section 1396r-5 to compute the community spouse income allowance after the institutionalized spouse is determined eligible for institutional care benefits. The department allows a deduction for the actual amount of health insurance premiums, deductibles, coinsurance charges and medical expenses, not subject to payment by a third party, incurred by a Medicaid recipient for programs involving post eligibility calculation of a patient responsibility, as authorized by the Medicaid State Plan and in accordance with 42 CFR 435.725.

Eligibility Procedures

Eligibility methodologies and standards will be the same as those used in determining eligibility under the State plan, and this waiver will continue to include only those persons age 65 or older or disabled, with income at or below 88 percent of the federal poverty level, whose assets do not exceed established limitations ($5,000 for individuals and $6,000 for a couple), and who are not eligible for Medicare or, if eligible for Medicare, are also eligible for and receiving Medicaid-covered institutional care services, hospice services, or home and community-based services.

Eligibility Changes

The State is planning to implement the applicable MAGI methodologies and MAGI equivalent income standards as required by federal law and regulation, excluding exempt individuals 65 or older.

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

☐ Yes ☒ No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

☐ Yes ☒ No (if no, please skip questions 8 - 11)

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

☐ Yes

☒ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment);

   Payment will be the same as State plan provider payment rates.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment); and

   Capitation rate methodology and managed care entities are same as for State plan.

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected (if additional space is needed, please supplement your answer with a Word attachment).

    No quality-based supplemental payments are being made to providers under this waiver.

Section V – Implementation of Demonstration

Implementation Schedule

Under this proposed renewal, the waiver would continue to operate as currently implemented for an additional three years, from January 1, 2014 through December 31, 2016.

How Potential Demonstration Participants Will be Notified and Enrolled into the Demonstration

Recipients will continue to be identified and notified in the State's routine eligibility determination process if they are eligible through this waiver.

Demonstration Benefits through Contracts with Managed Care Organizations

Waiver recipients will continue to receive services through the same MCOs contracted to provide State plan services. No procurement is planned.

Section VI – Demonstration Financing and Budget Neutrality

The State's assurance of budget neutrality that will be submitted with this renewal request is based upon the same methodology used for the initial waiver approval and prior renewal, and will not require an increase in the ceiling established for the current waiver period.

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The original approved waiver specified in the Special Terms and Conditions the aggregate financial cap on the amount of Federal Title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in Appendix E of this document. At the time of the last renewal, a permanent financial cap was established for this waiver and subsequent renewals, as described in the Expenditure Review section below.

Impermissible DSH, Taxes or Donations

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

How the Limit will be Applied

The ceiling limits identified below will apply to actual expenditures for demonstration, as reported by the State under Appendix E. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the end of the approved demonstration years, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Demonstration Year Cumulative Target Definition Percentage

DY 1	$2,030,843,575	8 percent
DY 2	$3,873,646,079	3 percent
DY 3	$5,697,644,476	1 percent
DY 4	$7,559,251,086	0.5 percent
DY 5	$9,402,053,590	0.0 percent

At the time of the prior renewal's approval for DY6-8 (calendar years 2011, 2012, 2013), the State and CMS mutually agreed to limit the future cumulative ceiling at the DY5 target of $9,402,053,590. The Expenditure to Date chart below identifies that beginning with DY6, the demonstration actual expenditures are being deducted from this agreed upon ceiling cap. The State will continue to demonstrate budget neutrality under this ceiling cap during the requested renewal for DY9-11 (calendar years 2014, 2015, 2016), as shown in the following table.

Expenditures to Date

Quarter	Date of Payment Expenditures	Target	Cumulative Target	Difference	Annual Cumulative Difference
Q1	$51,696,950	$507,710,894		456,013,944	
Q2	$132,235,096	$507,710,894		375,475,798	
Q3	$105,271,113	$507,710,894		402,439,781	
Q4	$146,356,839	$507,710,894	$2,030,843,575	361,354,055	1,595,283,577
Q5	$69,927,763	$460,700,626		390,772,863	
Q6	$79,047,475	$460,700,626		381,653,151	
Q7	$87,567,517	$460,700,626		373,133,109	
Q8	$90,210,963	$460,700,626	$3,873,646,079	370,489,663	3,111,332,363
Q9	$93,882,619	$455,999,599		362,116,980	
Q10	$103,108,178	$455,999,599		352,891,421	
Q11	$95,761,142	$455,999,599		360,238,457	
Q12	$96,128,169	$455,999,599	$5,697,644,476	359,871,430	4,546,450,652
Q13	$107,727,900	$465,401,653		357,673,753	
Q14	$106,365,677	$465,401,653		359,035,976	
Q15	$120,849,499	$465,401,653		344,552,154	
Q16	$133,665,863	$465,401,653	$7,559,251,086	331,735,790	5,939,448,324
Q17	$138,153,082	$460,700,626		322,547,544	
Q18	$144,229,555	$460,700,626		316,471,071	
Q19	$134,966,909	$460,700,626		325,733,717	
Q20	$148,599,566	$460,700,626	$9,402,053,590	312,101,060	7,216,301,716
Q21	$154,004,876	-		-	
Q22	$146,340,361	-		-	
Q23	$155,268,617	-		-	
Q24	$163,774,246	-		-	6,596,913,616
Q25	$165,396,338	-		-	
Q26	$184,629,761	-		-	
Q27	$165,063,579	-		-	
Q28	$168,922,270	-		-	5,912,901,668
Q29	$151,084,893			Jan-March 2013	5,761,816,775

Budget Neutrality Historic Trends and Projected Renewal Years

The following discussion is specific to this renewal budget neutrality analysis and is considered an addendum to the original waiver and prior renewal budget neutrality descriptions.
The historic table identifies all the actual waiver Demonstration Year expenditures and member months from DY1 (2006) through DY7 (2012), including the first three months of DY8 (2013).

Utilizing the historic trend rates calculated from these actual figures, the second table projects the waiver's expenditures and member months for the renewal years DY9-DY11 (calendar years 2014, 2015, 2016). As shown in the "With Waiver" projection, expenditures for the renewal period are expected to be approximately $2.7 billion, well under the funds remaining under the financial cap.

Historic Trend:
The member month figures in the historic table are an annual accumulation of the figures identified in the waiver quarterly progress reports submitted to CMS. The historic annual expenditure figures are the costs identified for this waiver in the State's quarterly CMS 64 reports for the same time periods. Costs and member month figures reported for DY1 (2006) are not included in the historic trend calculations utilized for the renewal projected years. The DY1 figures are not considered to be representative of current and future waiver population and cost characteristics. The State considers the annual trend patterns subsequent to 2006 to be a more accurate basis for measuring future waiver performance. The incomplete DY8 figures (January-March 2013) are shown for information only and are not utilized in the trend rate calculations.

Months of Aging:
The State identified 24 months for the months of aging calculation in the projection table. The 24 months are the number of months between the midpoint of the completed DY7 (2012) and the midpoint of the first renewal year DY9 (2014). The following illustrates this time period from July 2012 through June 2014:

	Months of Aging:
Jul -Dec 2012 (Completed DY7)	6 months
Jan-Dec 2013 (Incomplete DY8)	12 months
Jan-June 2014 (Renewal DY9)	6 months
	Total 24 months

Please see Appendix E for historic trends and projection tables.

Section VII – List of Proposed Waivers and Expenditure Authorities

The State requests waiver of Sections 1902(a)(10)(C) and 1903(a)(1) of the Social Security Act in order to provide eligibility and cover costs not otherwise matchable for this specific expansion population.

Section VIII – Public Notice

Dates for Public Notice Elements Required in 42 CFR 431.408:

April 24, 2013 In accordance with the consultation process outlined in the State's approved Medicaid State plan, letters were sent soliciting input and requesting consultation with Florida's two federally recognized Tribes, the Seminole Tribe and the Miccosukee Tribe. Please see Appendix B of this document for copies of the letters to the Tribes. No comments or questions were received from the Tribes.

April 29, 2013 Public Notice Document and public meeting and webinar schedule was posted to the Agency website at this link, http://ahca.myflorida.com/Medicaid/index.shtml (note Quick Link for MEDS-AD Renewal); and notice was published in Volume 39, Number 83 of the Florida Administrative Register https://www.flrules.org/Gateway/View_notice.asp?id=12938847 , which included a link to the MEDS-AD Renewal website: http://ahca.myflorida.com/Medicaid/MEDS-AD.shtml . Appendix B of this document contains a copy of the notice.

May 1, 2014 through May 30, 2013 Public Comment Period
Comments were solicited with instructions for submission by postal mail to the Agency for Health Care Administration, 2727 Mahan Drive, Bldg. 3 Room 2332A, Tallahassee, FL 32308, Attn: Marie Donnelly; or via electronic mail at MEDS-ADRenewal@ahca.myflorida.com . All comments received were posted to the Agency website at the MEDS-AD Renewal page as noted above, and were considered prior to submission of the waiver renewal request. Appendix C of this document contains a comprehensive listing of comments received and Agency responses.

May 15, 2013, 2:00 p.m. The first public meeting and webinar was presented at Medicaid Area Office 6, 6800 Dale Mabry Hwy., Suite 220, Tampa, Florida 33614, or via weblink at http://ahca.myflorida.com/Medicaid/MEDS-AD.shtml .

May 28, 2013, 1:00 p.m. The second public meeting with scheduled as part of the Medical Care Advisory Committee agenda at the Agency for Health Care Administration Headquarters, 2727 Mahan Drive, Tallahassee, Florida 32308. Appendix D of this document contains the presentation of the MEDS-AD Renewal plan to the public.

Hearing Summary

May 15 Meeting: There were no attendees from the public.

May 28 Meeting: The MEDS-AD Renewal presentation was presented twice, both as a webinar accessible through the weblink noted above, and at the scheduled meeting of the Medical Care Advisory Committee, which was attended by industry representatives for elders and the disabled and members of the media.

Mechanism Used to Notify the Public

In the notice published April 29, 2013 in Volume 39, Number 83 of the Florida Administrative Register and on its website, the Agency has provided a MEDS-AD Renewal link, http://ahca.myflorida.com/Medicaid/MEDS-AD.shtml , which can be readily accessed on the Agency's Medicaid Landing Page http://ahca.myflorida.com/Medicaid/index.shtml . The MEDS-AD Renewal page includes a link to submit comments via electronic mail to MEDS-ADRenewal@ahca.myflorida.com , or to the postal address to Agency for Health Care Administration, 2727 Mahan Drive, Bldg. 3 Room 2332A, Tallahassee, FL 32308, Attn: Marie Donnelly.

Comments Received by the State during the 30-day Public Notice Period

Comments received are posted to the Agency website at the MEDS-AD Renewal page as noted above, and were be considered prior to submission of this waiver renewal request. Appendix C of this document contains a comprehensive listing of comments received and Agency responses.

Summary of the State's Responses to Submitted Comments

Appendix C of this document contains a comprehensive listing of comments received and Agency responses.

Section IX – Demonstration Administration

Please provide the contact information for the State's point of contact for the Demonstration application.

Linda Macdonald
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Linda.Macdonald@ahca.myflorida.com

APPENDIX A

- Final Evaluation Report on the MEDS-AD Project, 2006-2010
- Interim Report and Preliminary Findings on Data Mining Waiver Amendment
- MEDS-AD Waiver Medication Therapy Management Program Interim Report for the Period January 2011 through December 2013
- MEDS-AD Waiver Key Informant Experiences—Preliminary Findings
- MTM Program Recipient Experiences—Preliminary Findings

Final Evaluation Report on the MEDS-AD Project, 2006-2010

November 1, 2012

Report to
Florida Agency for Health Care Administration

MEDS-AD Evaluation
Contract No. MED083

University of Florida

MEDS-AD originated as an optional program under Florida Medicaid. It was designed to provide medical assistance payments and services to aged or disabled individuals with limited assets and incomes at or below eighty-eight percent of the Federal poverty level. The Florida Legislature amended the MEDS-AD program with the implementation of Medicare Part D, and directed the Agency for Health Care Administration (AHCA) to seek federal waiver authority under the revised eligibility criteria. MEDS-AD transformed into a program for aged and disabled persons without Medicare coverage who meet the income and asset qualifications, and for dually eligible individuals who receive Medicaid institutional care, hospice, or home and community-based services. On November 22, 2005, CMS approved Florida's application for the 115 MEDS-AD demonstration waiver for a period of five years effective 1 January 2006.

For calendar years 2006 through 2010 Florida Medicaid applied a program of high intensity pharmacy case management services to a subgroup of MEDS-AD beneficiaries, specifically, those eligible for Medicaid only and not currently receiving institutional care services, home and community based services (HCBS) or hospice. The pharmacy services, in addition to providing access of appropriate medical care, were intended to maintain care in the community and prevent premature institutionalization.

Background and Waiver

The Federal waiver for the MEDS-AD program requires the program to be cost-neutral and incorporate innovative service concepts. The terms and conditions of the waiver require that the total cost of medical services and high intensity pharmacy case management for persons who are enrolled in the MEDS-AD program be compared with the estimated cost of institutional care avoided.

Goals and Objectives of the MEDS-AD Program

The stated objectives of the MEDS-AD program were to prevent premature admission to an institution by maintaining care in the community with access to appropriate health care services for vulnerable populations, and to implement a pharmacy case management for reducing adverse drug reactions and unnecessary drug utilization.

The MEDS-AD program operates under a Federal waiver that requires the program to be cost-neutral and incorporate innovative service concepts.

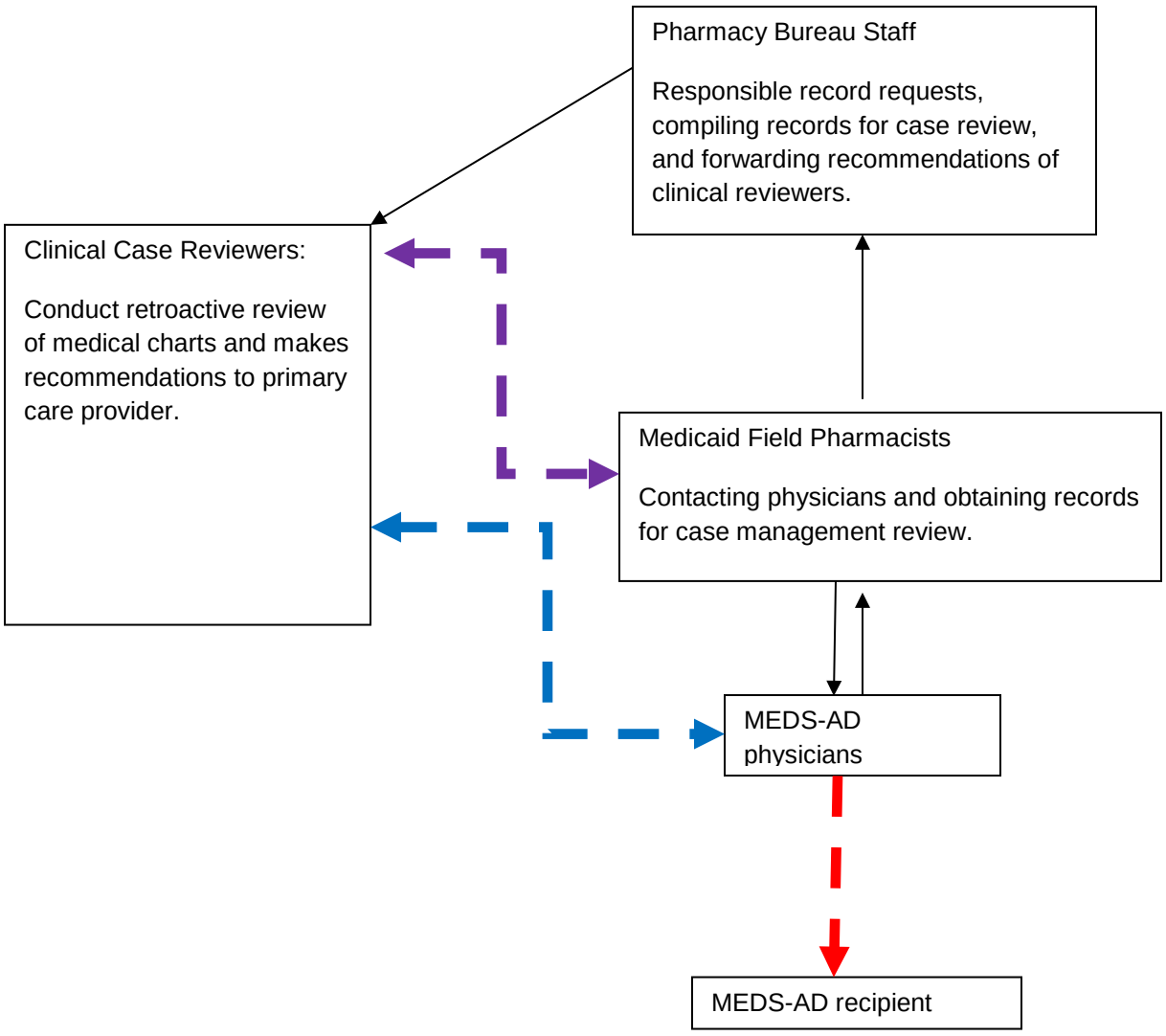
Brief Description of Program Operations

The evaluation team drafted a description of the MEDS-AD program operations gleaned from documents supplied by AHCA and Medicaid Pharmacy services as well

conferences with staff and a site visit to Medicaid offices in Tallahassee. The draft description was submitted to the Bureau for Pharmacy Services for review and comment. Figure 1 depicts the record retrieval and review process used for the MEDS-AD case management program.

Because there is no field in the Florida MMIS system for recording MEDS-AD enrollment, personnel in the office of Medicaid Pharmacy Services retrieve and screen the prescription claims history for MEDS-AD enrollees listed by the Department of Children and Families. Pharmacy Bureau staff developed a computer algorithm to identify those recipients who have intensive use of pharmacy services and based upon a manual verification of the prescription claims history, they select candidates for the Pharmacy Case Management initiative.

Figure 1. MEDS-AD Record Request and Review Process.



Evaluation Components and Key Findings

Written communications to physicians and provider satisfaction. The pharmacy staff reported good cooperation from physicians who received requests for patient records. There were no appeals, grievances or complaints made by patients or providers regarding the pharmacy case management program. There was no indication that any providers or beneficiaries dropped their enrollment in the Medicaid program as a result of the intervention program.

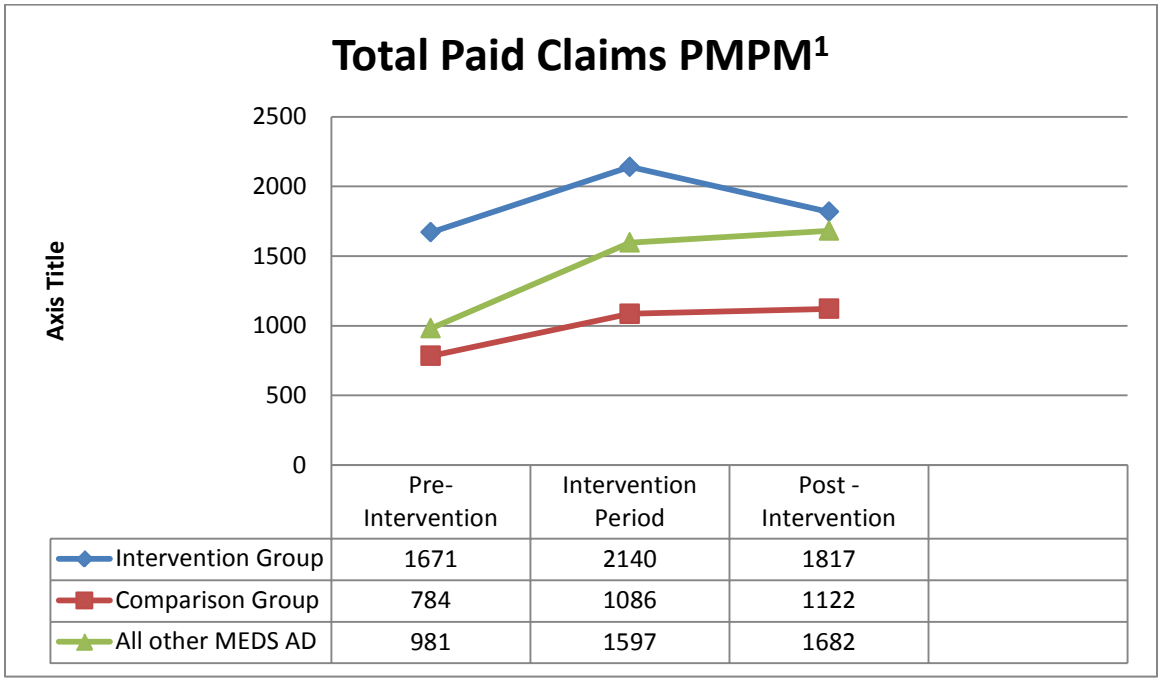
Key informant interviews revealed that medical records obtained from the providers were not always useful to the clinical reviewers because the records were often incomplete or difficult to read. Thus, the some reviews conducted under the current intervention program suffered from incomplete patient information. A series of recommendations emanated from the findings of the key informant interviews and were incorporated into a program modification and the subsequent request for an extension of the MEDS-AD waiver.

Beneficiary QoL and satisfaction: summary and interpretation. MEDS-AD beneficiaries who were the subject of clinical case reviews and a comparison group of program enrollees were contacted for a telephone interview as part of the evaluation process. Most reported having a personal doctor or nurse and rated that provider and their health care favorably. With regard to the case management intervention, recipients typically did not know that they were involved in an intervention because they were not directly included in the review process.

Use of Medicaid services and claims payments. The evaluation process included an examination of service use in terms of per-member per-month (PMPM) expenditures over three observation periods: (1) a period from the inception of the MEDS-AD waiver until the start of the case management intervention; (2) a period in which case management was being delivered, and (3) a period post intervention for those who were previously involved in the case management intervention. Beneficiaries selected for case management were compared with two groups of persons concurrently enrolled in MEDS-AD. One group was a comparison group formed by applying the same selection criteria used to identify those who were eventually enrolled in case management. The case management group and the comparison group were both examined against the PMPM payments for all MEDS-AD beneficiaries not in those two subgroups.

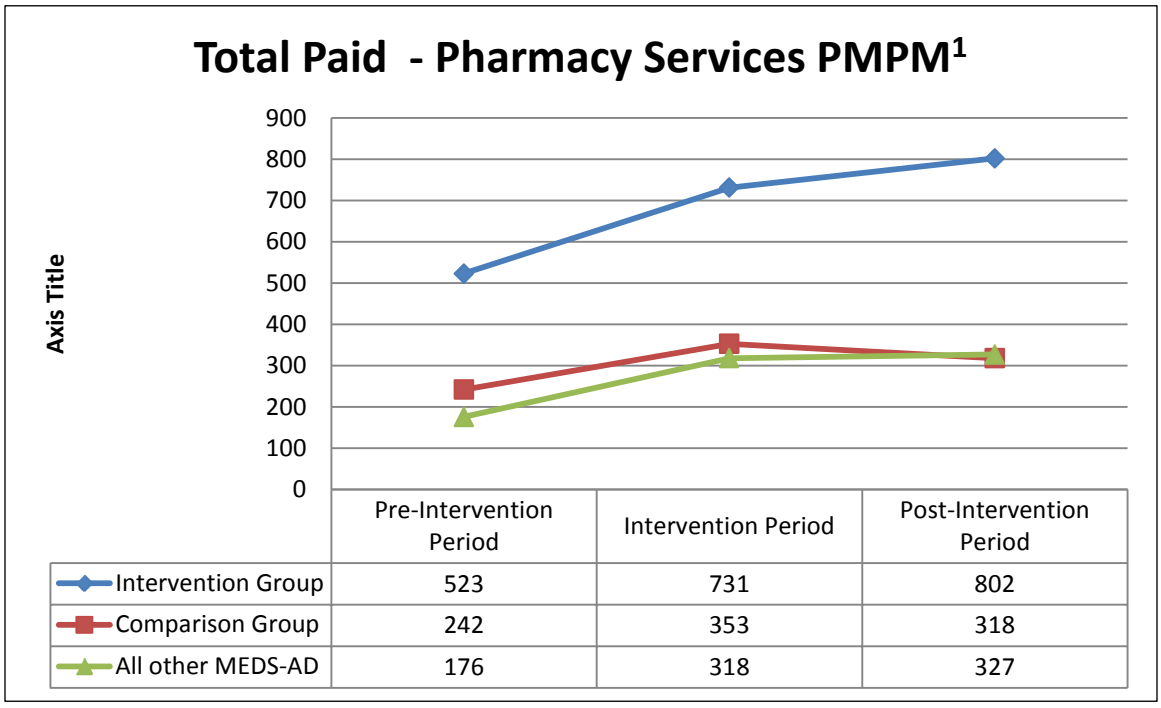
A key finding was that the case management group was the only segment for which the PMPM paid claims amount declined, as shown in the graph below (Figure 1). Although payments for pharmacy service continued to rise over time among those in the case management group, the rise was offset by in the intervention group through a reduction in PMPM expenditures for non-pharmacy services as shown in Figures 2 and 3.

Figure 1.



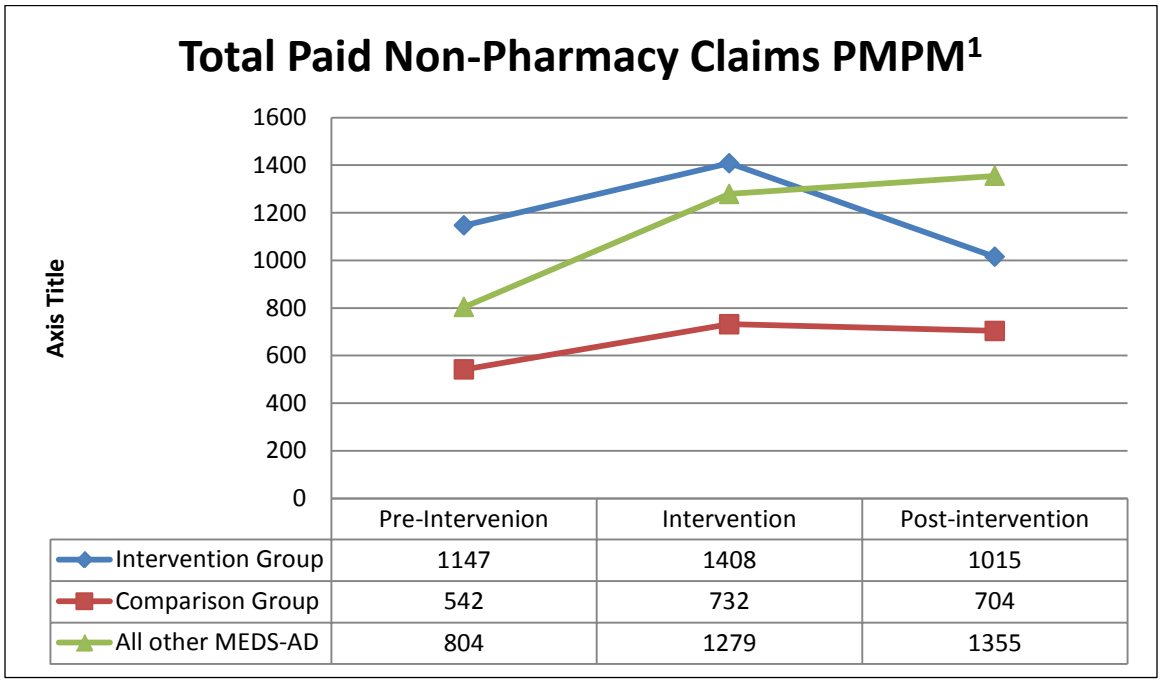
	Pre-Intervention	Intervention Period	Post - Intervention	
Intervention Group	1671	2140	1817	
Comparison Group	784	1086	1122	
All other MEDS AD	981	1597	1682	

Figure 2.



	Pre-Intervention Period	Intervention Period	Post-Intervention Period
Intervention Group	523	731	802
Comparison Group	242	353	318
All other MEDS-AD	176	318	327

Figure 3.



The remainder of this report covers the evaluation activities in more detail and concludes with a summary of lessons learned and recommendations for future consideration in providing services to aged and disabled individuals with multiple chronic medication conditions.

Survey of Beneficiaries: Findings and Conclusions

An important component of the evaluation was to ascertain the satisfaction of MEDS-AD enrollees. Florida Medicaid routinely assesses beneficiary satisfaction using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey which is a well-known and well-regarded tool for this purpose. The CAHPS survey was supplemented with SF-12 for measuring the quality of life and functional status of survey respondents covered under the MEDS-AD program.

Two telephone surveys of beneficiaries were conducted, one in spring 2009 and a second in early spring of 2010. Respondents included MEDS-AD recipients who had a pharmacy intervention (N=244) and a comparable group who did not (N=186). Attachment 1 includes details of the survey process along with a copy of the questions and responses.

Both groups described themselves in poor mental and physical health; however an even greater percentage of the intervention group rated their physical and mental on the lower end of the scale. Whereas 68% of the comparison group reported their overall health as fair or poor, 86% of the intervention group characterized their health as

fair or poor. Fifty-two percent of the comparison group reported that their mental health was fair or poor whereas 61% of the intervention group rated their mental health as fair or poor. Persons in the intervention group were also more likely to report health problems that persisted for 3 months or longer; limits in their ability to participate in moderate activity; and bounds on their capacity for engaging in day-to-day activities.

The response rate to the telephone survey was limited by not having current contact information for the recipients. During this period of time, many individuals were giving up land lines for cellular telephones, some of whom received phones from patient advocacy groups for reasons of personal safety. Although a relatively small number of persons declined to participate in the survey there were many who did not answer the telephone call or respond to messages. Failure to respond could be due to the poor health status of the enrollees who were contacted.

Key Informant Interviews: Findings and Conclusions

Key informants were selected for semi-structured interviews based upon their experience and varied perspectives on the MEDS-AD program. Those interviewed included representatives from the program operations staff; all physician and pharmacist clinical reviewers; Medicaid professional field staff and physicians who patients had been the subject of a MEDS-AD intervention. Attachment II describes the key informant process and findings.

The first round of key informant interviews generated a set of 14 recommendations for the MEDS-AD program for improving the timeliness and efficiency of program operations, increasing the benefit of the reviews to providers and patients, and enhancing the contributions and satisfaction of the clinical reviewers, field staff and program operations personnel. The recommendations made by the evaluation team in June 2010 were reviewed and considered by the Medicaid Pharmacy Bureau staff. Attachment III provides a copy of the recommendations that resulted from the key informant interviews.

The evaluation team and staff subsequently determined that there was no new input required from the clinical reviewers, prescribers or field staff relative to the suggestions for program modifications. Therefore, a second round of key informant interviews conducted in December 2, 2010 was targeted to members of the program staff responsible for the overall supervision and conduct of the MEDS-AD pharmacy case management program.

In the words of the key informants in the second round, the goal of MEDS-AD case management is to improve the care provided to patients by reducing poly-pharmacy when it exists and identify untreated medical indications which may require prescription medication. Coordination of care is a particular need because poly-pharmacy can be the result of individuals receiving care from multiple physicians. Although the Pharmacy Bureau does not have regulatory responsibility for additional

services under MEDS-AD, there exists a sense of professional responsibility to provide services that are likely to improve therapeutic outcomes. The MEDS-AD staff also acknowledged that although a pharmacy intervention to delay or lessen institutional care is a desirable goal, it may difficult to demonstrate these outcomes.

The case management intervention changed significantly under the renewed waiver authority. The changes were consistent with the recommendations that resulted from the first round of key informant interviews. Under the revised MEDS-AD intervention MEDS-AD beneficiaries identified by AHCA are invited to directly participate in a comprehensive medication review conducted over the telephone. Recommendations and actions plans generated by the comprehensive medication review produce timely recommendations to the beneficiary, a copy of which is communicated to the primary care provider identified by the patient.

Analysis of Paid Claims Data: Findings and Conclusions

A profile of the MEDS-AD population was constructed from information in the eligibility and paid claim files. It was found that somewhat more than one-half (67%) were women. Slightly less than one-third of the MEDS-AD population was under age 50 years, slightly more than one third of them ranged in age from 50-64 years, and the remaining third was 65 years or older. Nearly one-half (45%) had diagnosis of cardiovascular disease and nearly one-third (32%) were diagnosed with a mental disorder including psychoses (23%) and depression (8%). About half of the population had two or more chronic conditions, the most prevalent of which included with pulmonary diseases (24% of the population), arthritis (21%), and diabetes (18%). Relatively few were diagnosed with cancer (10%), dementia (less than 1%), substance abuse (less than 3%) or developmental disabilities (2.5%).

The evaluation team initially planned a longitudinal analysis of cost, quality and access parameters at the level of the individual beneficiary. However, the MEDS-AD population was continually in a state of flux. From January 2006 through September 2009 the majority of enrollees exhibited a gap in enrollment, of which slightly over half (53%) of the gaps were of 3 months duration or less. Although most beneficiaries were enrolled under fee-for-service, about 12% were enrolled in managed care plan at any point in time, with a little over 40% being in managed care at some point during their enrollment period. Having no claims to track during periods of ineligibility and no encounter claims under the HMO option, an analysis at the population level was the only feasible option.

Cost and use of services. Service use was examined over three observation periods: (1) from the inception of the MEDS-AD waiver on 1 January 2006 up to the initiation of the case management intervention on 1 October 2007, a period of 21 months; (2) a 15-month period during which case management was being delivered, October 2007 through December 2008; and (3) a 9-month post intervention period for those beneficiaries selected for case management from January 2009 through

September 2009. The analysis examined total paid claims as well as paid claims for pharmacy services and all other non-pharmacy Medicaid payments.

The per-member per-month (PMPM) claims payments for beneficiaries under case management were compared with two separate groups enrolled concurrently in the MEDS-AD program. A direct comparison group was formed by randomly selecting 700 individuals receiving multiple prescriptions using the same selection criteria that determined selection into case management. PMPM claims expenditures for the intervention and comparison groups were also compared with PMPM paid for all other MEDS-AD beneficiaries not in the two subgroups.

As shown previously in Figures 1-3, the PMPM expenditures for beneficiaries in the intervention group were greater than the PMPM expenditures in the comparison group prior to the start of the case management intervention. Table 1 summarizes the difference in PMPM expenditures between the three comparison group in the pre- and post-intervention period. PMPM expenditures in both the case management and comparison subgroups during the pre-intervention phase were greater than the PMPM expenditures for all other MEDS-AD enrollees. The PMPM for pharmacy services in the intervention group increased following the intervention however, PMPM amounts for non-pharmacy services declined as did the PMPM for total paid claims.

Table 1. Difference in PMPM MEDS-AD Expenditures Before and After Implementation of Case Management Program[1]

	PMPM – Total Medicaid expenditures	PMPM – Pharmacy Services	PMPM – Non-pharmacy services
Intervention Group N=715	$147 9% increase	$279 53% increase	($133) 12% decrease
Comparison Group N=700	$338 43% increase	$166 69% increase	$162 30% increase
All other Enrollees N=65,012	$701 71% increase	$151 9% increase	$551 69% increase

The PMPM amount increased over time in the comparison group as it had in the intervention group. However, unlike the intervention group, the PMPM for non-pharmacy services and total paid claims increased as well. All other MEDS-AD beneficiaries had the lowest PMPM for pharmacy services initially and experienced increases in the PMPM over the course of the observation periods. PMPM for MEDS-AD enrollees not considered for case management increased in all expenditure

[1] Includes all beneficiaries in the applicable group enrolled for 6 months or more in the MEDS-AD program; excludes beneficiaries enrolled in managed care plans, and beneficiaries not matched in the eligibility and/or paid claims file

categories. Additional detail on the PMPM expenditures for all groups over all periods in all expenditures categories can be found in Attachment IV.

Nursing home placement. Very few MEDS-AD beneficiaries experienced institutional placement during the course of the study; only 2.5% were admitted to a long term care facility and even fewer (1.5%) experienced a stay longer than 3 months. Less than 1% of enrollees are in an institution at any point in time. Additionally, roughly one percent of the population is enrolled in hospice at any point in time although nearly 4 percent of the total is enrolled in hospice at some point. It was not possible to reliably compare the cost and use of institutional services given small numbers combined with the difficulty of following specific beneficiaries over time.

Furthermore, many of the MEDS-AD beneficiaries met the eligibility criteria for more than one Medicaid waiver program. Once admitted to institutional care, services provided were outside the scope of the MEDS-AD program or the beneficiary was covered under an alternative program.

Drug utilization; adverse drug events. AHCA provided copies of the results of the clinical reviews completed from October 2007 through February 2009 involving 473 MEDS-AD recipients selected for pharmacy case management. The following table summarizes the nature of the potential drug therapy problems that were communicated to physicians. Reviewers made no recommendations for 122 (21%) of those reviewed. They offered 1,362 recommendations on behalf of 450 beneficiaries (mean 3.0 recommendations per beneficiary) through February 2009. The following table summarizes the type of recommendations made by the pharmacist and physician reviewers.

31.6%	No change recommended
47.4%	Monitor for drug-drug interactions
28.1%	Re-evaluate therapy
3.5%	Labs needed
14.0%	Recommend specific monitoring
3.5%	Encourage improved compliance with therapy
1.8%	Duplicate therapies noted
3.5%	Discontinue therapy
3.5%	Other clinical recommendation

Access to necessary services. Most beneficiaries who participated in the telephone surveys said they had primary care provider with whom they had a relatively long-standing relationship and with whom they were satisfied. Most respondents reported good communication with their physician including having received advice about preventive services. Language barriers did not seem to pose a major problem for the vast majority of enrollees. Most reported that their doctors were empathetic and listened to patient concerns. Physicians offered advice to patients about their health

and care plans. Although the numbers of smokers in each group was relatively small the vast majority of smokers reported that their doctors had advised them to quit.

Some access problems were reported in access to specialists, tests and treatments, and prescription medications. Reasons given for problems with access to specialists included uncertainty about where to locate a specialist, or in finding a convenient appointment time or with an acceptable travel distance. About one-third of those interviewed reported problems that included not having enough specialists to choose from, desiring access to a specialist that was not part of their plan's network, or experiencing a delay with a prior authorization or approval for the visit.

Despite some concerns about access to services, most of the population rated their health care and their personal physician highly.

Summary and Recommendations

A review of the literature at the outset of this evaluation project suggested that despite applying clinical guidelines and monitoring quality measures, there is a group of patients that are difficult to manage,[2] even if there is a multi-disciplinary, collaborative effort on behalf of the patient.[3] An evaluation of the Iowa Medicaid Pharmaceutical Case Management Program found no difference in institutional or medical expenditures among the participants after nine months of observation in spite of significantly improved medication use as measured by the Medication Appropriateness Index (MAI). The Iowa evaluation team anticipated that savings would not be apparent in the short term and, in a population with frail and declining health status, cost saving may not be expected.[4]

In an analysis conducted by Mathematica Policy Research, evidence on effective care coordination showed that strong medication management is a characteristic of programs that have successfully provided coordinated care for high-risk, high-cost patient populations.[5] Other important characteristics of successful programs are:

- Frequent face-to-face interactions with patients that build rapport among team members and comfort for patient;
- Caseloads small enough for care managers to operate effectively, with ongoing training and feedback for care managers;

[2] Mallet L, Spinewine A, Huang A. The challenge of managing drug interaction in elderly people. Lancet 2007: 370:185-191.

[3] Spinewine A, Swine C, Dhillon S, Lambert P, Nachega JB, Wilmnotte L, Tulkens PM. Effect of a collaborative approach on the quality of prescribing for geriatric inpatients: a randomized, controlled trial. J Am Geriatr Soc 2007; 55:658-665.

[4] Chrischilles EA, Carter B, Voelker M, Scholz D, Chen-Hardee S, et al. Iowa Medicaid Pharmaceutical Case Management Program Evaluation. Iowa City: Report to the DHS Appropriations Subcommittee, March 5, 2003.

[5] Brown RS, Peikes D, Peterson G, Schore J, Razafindrakoto CM. Six features of Medicare coordinated care demonstration programs that cut hospital admissions of high-risk patients. Health Affairs 2012; 31: 1156-1165.

- A strong, evidence-based patient education component to help ensure adherence to prescriptions and other treatment recommendations;
- Care setting transitions (from hospitals to outpatient care) that are managed in a comprehensive and timely way;
- Care coordinators who serve as a "communications hub" between multiple providers; and
- Resources for addressing psycho-social issues, such as loneliness and depression.

A number of innovative programs have resulted from the provisions for Medication Therapy Management (MTM) services under Medicare Part D. . An extensive review of randomized controlled trials concluded that two service elements are critical to an effective MTM program: (1) selecting patients with specific therapeutic problems and (2) timely communication with primary care providers along with routine patient follow-up.[6] Florida Medicaid should continue to monitor the development and evaluation of these new initiatives to identify programs that demonstrate cost saving and improvements in health-related quality of life for those enrolled in the MEDS-AD program

All of these findings and recommendations are consistent with lessons learned from the MEDS-AD intervention.

[6] Kucukarslan SN, Hagan AM, Shimp LA, Gainther CA, Lewis NJW. Integrating medication therapy management in the primary care medical home: a review of randomized controlled trials. Am J Health-Syst Pharm 2011; 68:335-345.

Attachment I

Survey of Beneficiaries: Findings and Conclusions

Survey Methods

The survey questions for the telephone interviews with MEDS-AD enrollees included self-reported assessments of health and functional status, as well as information on access, satisfaction and coordination of care under the MEDS-AD program. The survey was a composite of validated survey instruments that are widely used. The components were:

1. **CAHPS (Consumer Assessment of Health Plans Survey), Version 3**. The CAHPS is a family of survey instruments designed to assess experience and satisfaction with care among health plan enrollees regarding primary care, specialty care and health plan administration. It was developed with funding from the Agency for Health Care Research and Quality (AHRQ), extensively tested and validated for use in Medicaid, Medicare, SCHIP and commercial plans. Versions of the CAHPS are available in several languages and tailored to different types of health care arrangements and a variety of respondents. This survey uses incorporates core questions from the adult Medicaid version as well as supplemental questions related to chronic conditions, dental care and pharmacy services in both English and Spanish.

2. **MOS-SF-12, Version 2**: SF-12 assesses health status in both physical and mental health domains. It is a well-validated instrument and has been used around the world. The English and American-Spanish versions of the SF-12 were used in this survey.

3. **PHQ-2**: The PHQ-2 is a two-question, standardized instrument for assessing depression. It is a relatively new instrument, but it has been validated in several populations to date and is available in English and Spanish versions.

The time required for the survey was approximately 20-30 minutes. If the beneficiary was physically or mentally unable to complete the survey, the interviewer asked to speak with a caregiver who could respond on behalf of the beneficiary. Proxy respondents verified that they were over 18 years old and knowledgeable of the health care and health care needs of the listed respondent. Spanish-speaking interviewers were available upon request of the respondent.

Telephone interviews were conducted by trained interviewers at the Bureau of Economic and Business Research (BEBR), an applied research center in the Warrington College of Business Administration at the University of Florida. The BEBR has conducted numerous surveys for the Florida Agency for Health Care Administration and other state agencies. IRB-1 at the University of Florida Health Sciences Center reviewed and approved the survey and the protocols.

A letter, printed on UF stationary and personally signed by the PI, was sent by first class mail to every person on the target list of beneficiaries to inform them of the upcoming survey. The letter provided background information, contact information for

the PI and encouraged participation in the process. The telephone survey was conducted in two phases.

In the first phase all beneficiaries who had been reviewed under the High Risk Pharmacy Case Management component of MEDS-AD (N=715) were contacted in February and March 2009. Of the initial contact letters informing the beneficiary of the upcoming telephone survey, eight letters were returned as undeliverable. We were contacted by, or on behalf of, an additional 8 recipients. Two individuals were deceased; others provided updated or preferred contact information and received answers to their questions about the nature and purpose of the survey.

Of the 715 names provided to the Survey Research Center, 283 were non-working, disconnected, wrong number, etc. In order to increase the responses, the research center worked with a commercial sampling company to match those cases with a telephone number. An additional 20 responses were obtained through the number matching process.

The Survey Research Center made 20 attempts to contact each respondent at various times and on multiple occasions before considering the contact to be unreachable. This occurred for 18 cases. Interviewers were unable to reach 98 persons due to a non-working telephone number, 61 persons with a disconnected number, and 1 having an unlisted number. There were 100 cases in which the interviewer was told that this was an incorrect number for the targeted respondent. A call could not be completed in 6 cases when the caller connected with a fax or data line or in one case due to other technical problems.

Nine individuals refused to participate; 89 others declined. Some cited ill health or difficulty hearing and speaking among a variety of other reasons. A message requesting the respondent to return the call was left if the beneficiary was unavailable or when the caller reached an answering machine. In 62 cases no return call was received. In another 18 cases, a return call was made by someone other than the listed recipient. Seven persons spoke a language other than English or Spanish and were not interviewed.

The second phase of the telephone survey solicited responses from MEDS-AD beneficiaries who receive multiple prescription medications but had not been selected for intervention. The purpose of the second phase of the telephone survey was to provide a basis of comparison with beneficiaries who had received an intervention and who responded to the first survey.

To generate a comparison group of MEDS-AD enrollees, researchers at UF matched a list of current MEDS-AD beneficiaries who had not been selected for intervention against data from the recipient eligibility and paid claims files. This resulted in a pool of 5,111 persons. The list was arrayed by the number of paid prescription claims and 699 individuals receiving multiple prescriptions were randomly selected for the second phase of the beneficiary survey.

Again participants were contacted by mail before the survey was initiated. The letters were mailed by first class post to each person selected for the survey advising them that the survey was being conducted; 78 of those letters were returned as undeliverable.

There were 186 surveys completed in Phase II. A total of 308 beneficiaries could not be located for the interview. Ability to contact selected respondents was most often due to disconnected and non-working telephones (197), or wrong numbers (111). Ninety-four (94) persons declined to be interviewed, 8 spoke a language other than English or Spanish, and another 103 individuals did not answer the call or return the call in response to messages requesting their cooperation.

Responses to both phases of the survey are shown in the following tables.

	Questionnaire Item*	Comparison group (N= 186)		Intervention group (N-244) (weighted)	
		N	%	N	%
Q3	**Had Illness or Injury Needing Immediate Care in last 6 months**				
1	Yes	81	43.5	145	59.4
2	No	105	56.5	95	38.9
Q4	(For those who had an illness or injury needing immediate care) **Got Immediate Care for Illness or Injury as Soon as Desired**				
1	Never	1	1.2	2	1.4
2	Sometimes	10	12.3	20	13.8
3	Usually	7	8.6	25	17.2
4	Always	57	70.4	90	62.1
Q5	**Made Appointment for Non-Urgent Health Care at Doctor's Office or Clinic**				
1	Yes	152	81.7	207	84.8
2	No	34	18.3	36	14.8
Q6	**Got Appointment for Non-Urgent Health Care as Soon as Desired**				
1	Never	8	5.3	6	2.9
2	Sometimes	17	11.2	26	12.6
3	Usually	23	15.1	35	16.9
4	Always	100	65.8	129	62.3

AR1	**Days Waiting Between Making an Appointment and Seeing a Provider**				
1	Same day	15	9.9	25	12.1
2	1 day	11	7.2	22	10.6
3	2 to 3 days	25	16.4	47	22.7
4	4 to 7 days	28	18.4	51	24.6
5	8 to 14 days	14	9.2	19	9.2
6	15 to 30 days	26	17.1	16	7.7
7	31 to 60 days	9	5.9	10	4.8
8	61 to 90 days	5	3.3	2	1.0
9	91 days or longer	3	2.0	2	1.0
AR2	**Delay in Appointment due to Limited Hours or Availability**				
1	Never	69	45.4	85	41.1
2	Sometimes	32	21.1	65	31.4
3	Usually	18	11.8	19	9.2
4	Always	31	20.4	28	13.5
UT1	**# of Emergency Room Visits**				
0	None	120	64.5	131	53.7
1	1	35	18.8	57	23.4
2	2	12	6.5	20	8.2
3	3	7	3.8	12	4.9
4	4	4	2.2	5	2.0
5	5 to 9	2	1.1	11	4.5
6	10 or more	1	0.5	4	1.6
Q7	**Number of Times Went to Doctor's Office or Clinic for Care for Self**				
0	None	14	7.5	13	5.3
1	1	21	11.3	19	7.8
2	2	41	22.0	41	16.8
3	3	33	17.7	33	13.5
4	4	16	8.6	31	12.7
5	5 to 9	34	18.3	54	22.1
6	10 or more	9	4.8	36	14.8

H1	**Discussed Illness Prevention with Doctor in Last 6 Months**				
1	Never	35	22.7	32	15.0
2	Sometimes	33	21.4	51	23.8
3	Usually	32	20.8	29	13.6
4	Always	47	30.5	92	43.0
Q8	**Rating of Healthcare in Last 6 months**				
0	0 Worst health care possible	1	0.6	3	1.4
1	1				
2	2	4	2.6		
3	3	3	1.9	4	1.9
4	4	1	0.6	9	4.2
5	5	8	5.2	20	9.3
6	6	11	7.1	5	2.3
7	7	13	8.4	15	7.0
8	8	35	22.7	44	20.6
9	9	21	13.6	19	8.9
10	10 Best health care possible	51	33.1	90	42.1
	Mean Rating of Health Care in Last 6 Months	7.44+/-3.8		7.78+/-3.3	
AH1	**Visited Doctor's Office or Clinic for After Hours Care**				
1	Yes	10	6.5	30	14.0
2	No	143	92.9	182	85.0
AH2	**How Often was it Easy to Get Needed After Hours Care**				
1	Never	1	10.0	7	23.3
2	Sometimes	2	20.0	6	20.0
3	Usually			3	10.0
4	Always	6	60.0	12	40.0

	(For those who reported it was not "always" easy to get after hours care) **Reasons it was not easy to get needed after hours care**				
AH3_1	**Did not know where to go for after hours care**				
1	Yes			3	18.8
2	No	3	100.0	13	81.3
AH3_2	**Not sure where to find a list of doctor's offices or clinics in health plan or network that are open for after hours care**				
1	Yes			6	37.5
2	No	3	100.0	10	62.5
AH3_3	**The doctor's office or clinic that had after hours care was too far away**				
1	Yes	1	33.3	5	31.3
2	No	2	66.7	11	68.8
AH3_4	**Office or clinic hours for after hours care did not meet subject's needs**				
1	Yes			6	37.5
2	No	3	100.0	10	62.5
AH3_5	**Other**				
1	Yes	1	33.3	7	43.8
2	No	2	66.7	9	56.3
CC11	**Need for Special Therapy, Such as Physical, Occupational, or Speech Therapy**				
1	Yes	34	18.3	70	28.7
2	No	148	79.6	170	69.7
CC12	(For those who needed special therapy) **How Often was it Easy to Get Special Therapy through Health Plan**				
1	Never	3	8.8	9	12.9
2	Sometimes	5	14.7	9	12.9
3	Usually	3	8.8	12	17.1
4	Always	19	55.9	33	47.1
Q9	**Has Personal Doctor**				
1	Yes	159	85.5	223	91.4
2	No	24	12.9	18	7.4

CC1	**General Doctor or Specialist Doctor**				
1	General Doctor (Family practice or internal medicine)	132	83.0	176	78.9
2	Specialist Doctor	17	10.7	30	13.5
CC2	**How Long Seeing this Personal Doctor**				
1	Less than 6 months	11	6.9	16	7.2
2	At least 6 months but less than 1 year	14	8.8	14	6.3
3	At least 1 year but less than 2 years	21	13.2	23	10.3
4	At least 2 years but less than 5 years	53	33.3	85	38.1
5	5 years or more	46	28.9	78	35.0
CC3	**Subject has a Physical or Mental Condition that Seriously Interferes with Ability to Work, Attend School, or Manage Day-to-Day Activities**				
1	Yes	107	67.3	188	84.3
2	No	49	30.8	26	11.7
CC4	**Does Personal Doctor Understand How Health Problems that Affect Day-to Day Life**				
1	Yes	100	93.5	177	94.1
2	No	7	6.5	9	4.8
Q10	**Visits to Personal Doctor in Last 6 Months**				
0	None	6	3.8	5	2.2
1	1	13	8.2	12	5.4
2	2	45	28.3	38	17.0
3	3	27	17.0	37	16.6
4	4	14	8.8	26	11.7
5	5 to 9	33	20.8	61	27.4
6	10 or more	10	6.3	29	13.0
Q11	**Doctor Explained Things So That Patient Could Understand**				
1	Never	9	6.3	5	2.5
2	Sometimes	16	11.3	19	9.4
3	Usually	10	7.0	23	11.3
4	Always	105	73.9	154	75.9

Q12	**Doctor Listened Carefully to Subject**				
1	Never	2	1.4	3	1.5
2	Sometimes	13	9.2	23	11.3
3	Usually	7	4.9	13	6.4
4	Always	118	83.1	163	80.3
C1	**Experienced Difficulty Communicating With Doctor Due to Speaking Different Languages**				
1	Never	96	67.6	141	69.5
2	Sometimes	9	6.3	17	8.4
3	Usually	3	2.1	5	2.5
4	Always	30	21.1	36	17.7
Q13	**Doctor Showed Respect for What Subject Said**				
1	Never	7	4.9	5	2.5
2	Sometimes	4	2.8	16	7.9
3	Usually	9	6.3	13	6.4
4	Always	120	84.5	168	82.8
Q14	**Doctor Spent Enough Time With Subject**				
1	Never	2	1.4	6	3.0
2	Sometimes	14	9.9	22	10.8
3	Usually	16	11.3	23	11.3
4	Always	107	75.4	150	73.9
CO1	**Called Doctor's office During Regular Office Hours**				
1	Yes	89	56.0	155	69.5
2	No	69	43.4	67	30.0
CO2	(For those who called doctor's office during regular hours) **Got Needed Help or Advice When Called Doctor's Office During Regular Office Hours**				
1	Never	3	3.4	4	2.6
2	Sometimes	14	15.7	16	10.3
3	Usually	10	11.2	23	14.8
4	Always	62	69.7	110	71.0

CO3	**Called Doctor's Office After Regular Office Hours**				
1	Yes	27	17.0	54	24.2
2	No	132	83.0	168	75.3
CO4	(For those who called doctor's office after regular hours) **Got Needed Help or Advice When Called Doctor's Office After Regular Office Hours**				
1	Never	1	3.7	5	9.3
2	Sometimes	6	22.2	8	14.8
3	Usually	4	14.8	5	9.3
4	Always	16	59.3	35	64.8
	Reasons for Not Getting Help When Calling After Regular Office Hours				
CO5_1	**Did not know what number to call**				
1	Yes	8	72.7	17	94.4
2	No	3	27.3	1	5.6
CO5_2	**Left a message but no one returned call**				
1	Yes	5	45.5	8	44.4
2	No	6	54.5	10	55.6
CO5_3	**Could not leave a message at the number phoned**				
1	Yes	2	18.2	6	33.3
2	No	9	81.8	12	66.7
CO5_4	**Another doctor was covering for subject's personal doctor**				
1	Yes	4	36.4	6	33.3
2	No	7	63.6	12	66.7
CO5_5	**Other reason**				
1	Yes	6	54.5	5	27.8
2	No	5	45.5	13	72.2

Q15	**Rating of Personal Doctor**				
0	0 Worst personal doctor possible	3	1.9	1	0.4
1	1			1	0.4
2	2			2	0.9
3	3			1	0.4
4	4	4	2.5	2	0.9
5	5	7	4.4	8	3.6
6	6	3	1.9	7	3.1
7	7	9	5.7	8	3.6
8	8	29	18.2	19	8.5
9	9	13	8.2	18	8.1
10	10 Best personal doctor possible	88	55.3	155	69.5
	Mean Rating of Personal Doctor	8.4 +/- 3.1		9.01+/- 2.2	
CC6	**Were Any Decisions Made about Subject's Health Care**				
1	Yes	103	55.4	161	66.0
2	No	79	42.5	72	29.5
CC7	(For those who reported that health decisions were made) **How Often was Subject as Involved as He/She Wanted in Health Care Decisions**				
1	Never	9	8.7	9	5.6
2	Sometimes	10	9.7	18	11.2
3	Usually	11	10.7	15	9.3
4	Always	69	67.0	115	71.4
CC8	(For those who reported that health decisions were made)**How Often was it Easy to Get Heath Providers to Agree with Subject on the Health Management**				
1	Never	4	3.9	6	3.7
2	Sometimes	17	16.5	37	23.0
3	Usually	15	14.6	32	19.9
4	Always	65	63.1	81	50.3
H5	**Subject Received Care from a Health Provider Other Than Personal Doctor**				
1	Yes	105	56.5	146	59.8
2	No	78	41.9	93	38.1

H6	**How often did Personal Doctor seem Informed and Up-to-Date About Care Given by Other Doctors or Health Providers**				
1	Never	6	5.7	3	2.1
2	Sometimes	12	11.4	17	11.6
3	Usually	19	18.1	23	15.8
4	Always	65	61.9	97	66.4
OHP3	**Did Anyone from the Subject's Health Plan, Doctor's Office or Clinic Help Coordinate Care Among Doctors and Other Health Providers**				
1	Yes	63	60.0	107	73.3
2	No	36	34.3	33	22.6
	(For those who received help with care coordination) **Who helped coordinate care**				
OHP4_1	Someone from health plan	26	41.3	48	44.9
OHP4_2	Someone from doctor's office or clinic	45	71.4	81	75.7
OHP4_3	Someone from another organization	11	17.5	16	15.0
OHP4_4	A friend or family member	22	34.9	23	21.5
OHP4_5	You	35	55.6	55	51.4
OHP5	(For those who received help with care coordination) **Subject Satisfaction with the Help Received to Coordinate Care**				
1	Very dissatisfied	1	1.8	3	3.0
2	Dissatisfied	2	3.5	5	5.0
3	Neither dissatisfied nor satisfied			3	3.0
4	Satisfied	25	43.9	40	40.0
5	Very Satisfied	27	47.4	49	49.0
PD1	**Same Personal Doctor Before Joining the Health Plan**				
1	Yes	88	47.3	120	49.2
2	No	94	50.5	117	48.0

PD2	(For those who changed doctors after joining health plan)**Since Joining the Health Plan, How Often was it Easy for Subject to get a Personal Doctor He/She was "Happy With"**				
1	Never	16	17.0	16	13.7
2	Sometimes	21	22.3	20	17.1
3	Usually	8	8.5	22	18.8
4	Always	44	46.8	55	47.0
SUPPB	(For those who changed doctors after joining health plan) **Rating of Number of Doctors to Choose From**				
1	Excellent	23	24.5	32	27.4
2	Very Good	16	17.0	21	17.9
3	Good	25	26.6	21	17.9
4	Fair	12	12.8	9	7.7
5	Poor	8	8.5	16	13.7
6	No experience	6	6.4	11	9.4
IM2	**When Visiting Personal Doctor's Office, How Often was Patient Examined on the Examination Table**				
1	Never	12	8.5	20	9.9
2	Sometimes	36	25.4	50	24.6
3	Usually	19	13.4	28	13.8
4	Always	73	51.4	102	50.2
IM3	**When Visiting Personal Doctor's Office, How Often was Subject Weighed**				
1	Never	2	1.4	4	2.0
2	Sometimes	5	3.5	8	3.9
3	Usually	7	4.9	10	4.9
4	Always	126	88.7	181	89.2
Q16	**Has Subject Tried to Make an Appointment with a Specialist in Last 6 Months**				
1	Yes	95	51.1	150	61.5
2	No	90	48.4	94	38.5

Q17	**In Last 6 Months, How Often was it Easy to Get Appointments with Specialists**				
1	Never	11	11.6	19	12.7
2	Sometimes	13	13.7	26	17.3
3	Usually	21	22.1	19	12.7
4	Always	47	49.5	81	54.0
	(For those who reported it was not always easy to get an appointment with a specialist)**Reasons it was Not Easy to Get an Appointment with a Specialist**				
AS1_1	**Doctor did not think subject needed to see a specialist**				
1	**Yes**	6	13.3	9	14.1
2	No	39	86.7	55	85.9
AS1_2	**Health plan approval or authorization was delayed**				
1	Yes	14	31.1	21	32.8
2	No	31	68.9	43	67.2
AS1_3	**Not sure where to find a list of specialists in health plan or network**				
1	Yes	12	26.7	20	31.3
2	No	33	73.3	44	68.8
AS1_4	**The specialists were too far away**				
1	Yes	13	28.9	29	45.3
2	No	32	71.1	35	54.7
AS1_5	**Not have enough specialists to choose from**				
1	Yes	21	46.7	22	34.4
2	No	24	53.3	42	65.6
AS1_6	**The specialist that subject wanted did not belong to his/her health plan or network**				
1	Yes	22	48.9	32	50.0
2	No	23	51.1	32	50.0
AS1_7	**Could not get an appointment at a time that was convenient**				
1	Yes	19	42.2	14	21.9
2	No	26	57.8	50	78.1
AS1_8	**Other reason**				
1	Yes	13	28.9	27	42.2
2	No	32	71.1	37	57.8

Q18	**How Many Different Specialists Seen in Last 6 Months**				
0	None	55	29.6	57	23.4
1	1 specialist	49	26.3	52	21.3
2	2	40	21.5	55	22.5
3	3	19	10.2	30	12.3
4	4	8	4.3	25	10.2
5	5 or more specialists	8	4.3	15	6.1
CC5	**How Many Specialist Visits in Last 6 Months**				
1	1	36	29.0	32	18.1
2	2	26	21.0	30	16.9
3	3	14	11.3	20	11.3
4	4	11	8.9	20	11.3
5	5 to 9	22	17.7	40	22.6
6	10 or more	9	7.3	20	11.3
Q19	**Rating of Specialist**				
0	0 Worst specialist possible	2	1.6	1	0.6
1	1	2	1.6		
2	2			1	0.6
3	3	1	0.8	1	0.6
4	4	2	1.6	2	1.1
5	5	2	1.6	4	2.3
6	6	3	2.4	6	3.4
7	7	6	4.8	10	5.6
8	8	8	6.5	20	11.3
9	9	20	16.1	13	7.3
10	10 Best specialist possible	77	62.1	117	66.1
	Mean Rating of Specialist				
UT2	**Was the Specialist that Was Seen Most Often the Same Doctor as Subject's Personal Doctor?**				
1	Yes	47	37.9	67	37.9
2	No	69	55.6	105	59.3

Q20	**In Last 6 months, has Subject Tried to Get Any Care, Tests, or Treatment through Health Plan**				
1	Yes	84	45.2	126	51.6
2	No	96	51.6	106	43.4
Q21	(For those who Tried to Get Care, Tests, or Treatment) **How Often was it Easy to Get Care, Tests, or Treatment Through Health Plan**				
1	Never	6	7.1	16	12.7
2	Sometimes	21	25.0	31	24.6
3	Usually	13	15.5	17	13.5
4	Always	43	51.2	60	47.6
Q22	**Has Subject Tried to Get Information or Help from Health Plan's Customer Service**				
1	Yes	53	28.5	85	34.8
2	No	131	70.4	153	62.7
Q23	(For those who Tried to Get Help from Customer Service) **How Often did Health Plan's Customer Service Give Information or Help Needed**				
1	Never	8	15.1	14	16.5
2	Sometimes	15	28.3	26	30.6
3	Usually	4	7.5	8	9.4
4	Always	22	41.5	35	41.2
Q24	(For those who Tried to Get Help from Customer Service)**How Often did Health Plan's Customer Service Staff Treat Enrollee with Courtesy and Respect**				
1	Never			8	9.4
2	Sometimes	9	17.0	12	14.1
3	Usually	8	15.1	7	8.2
4	Always	35	66.0	58	68.2
Q25	**Did Health Plan Give Subject Any Forms to Fill Out**				
1	Yes	46	24.7	80	32.8
2	No	137	73.7	155	63.5

PM3	(For those who got new prescriptions or refills) **How often did Enrollee Get the Needed Prescription Medicine Through Health Plan**				
1	Never			6	3.0
2	Sometimes	11	7.2	23	11.3
3	Usually	20	13.1	36	17.7
4	Always	121	79.1	135	66.5
T1	**Has Subject Called Health Plan to Get Help with Transportation in Last 6 Months**				
1	Yes	24	12.9	35	14.3
2	No	161	86.6	207	84.8
T2	(For those who called for transportation help) **How often did Subject Receive the Needed Transportation Help**				
1	Never	3	12.5	5	14.3
2	Sometimes	4	16.7	7	20.0
3	Usually	5	20.8	1	2.9
4	Always	12	50.0	20	57.1
T3	(For those who called for transportation help and reported getting that help) **How Often did the Transportation Help Meet the Subject's Needs**				
1	Never	1	4.8	1	3.3
2	Sometimes	2	9.5	4	13.3
3	Usually	4	19.0	1	3.3
4	Always	14	66.7	22	73.3

Attachment II

Key Informant Interviews: Findings and Conclusions

Key informants were selected for their experience and varied perspectives on the MEDS-AD program. Individuals with a variety of roles in the program were contacted throughout the evaluation process. The contacts are summarized below.

I. Persons responsible for MEDS-AD program operations were interviewed about the policies and procedures used in the case review process. The role and responsibilities of key staff were identified. The greatest share of the information was obtained from interviews conducted on February 9, 2009 at AHCA offices in Tallahassee. As reported in Deliverable #3, the evaluators produced a narrative description of the MEDS-AD program which was reviewed and approved by those who provided information to the evaluators. Additional information and updates have been communicated by email and teleconferencing throughout the course of the evaluation.

II. All of the physicians and clinical pharmacists who performed chart reviews were interviewed through scheduled conference calls. The first pharmacist interview occurred on February 27, 2009, followed by the first physician interview on April 24, 2009. A second physician and a pharmacist were added as clinical reviewers in July 2009 and were interviewed on November 4 and November 6, 2009, respectively. All interviews were approximately 45 minutes in length and conducted by the same two evaluators. All those interviewed read and approved written summaries of their respective interviews.

III. Two Medicaid pharmacists assigned to area offices in the state were interviewed on July 29 and July 31, 2009, respectively. These pharmacists are responsible for obtaining and transmitting chart information from physicians' offices regarding the patients who are selected for the intervention.

IV. Interviews were requested with physicians whose patients had been the subject of a MEDS AD review. The evaluation team identified a representative group of physicians from around the state, some that had been contacted about a single patient and some with multiple contacts regarding MEDS-AD patients. Multiple attempts over a period of 6 weeks produced only one completed physician interview. As the physician interviews were not yielding information of value to the evaluation, physician provider interviews were suspended.

Outline of questions and process for key informant interviews

A. Preparation for Interview
   1. Obtain the records of the last 40 patients reviewed in the month including all the information the case reviewers are given to come up with their recommendations
   2. Verify that the field pharmacists are able to obtain the records and information necessary for the case reviewers to make a complete recommendation
   3. Document the process case reviewers use to generate their recommendations, including

a. Reliance on evidence based practice guidelines
b. Application of the Medication Appropriateness Index (MAI)

4. Characterize the nature of the clinical recommendations.
5. Compare the process used by case reviewers with what was originally proposed
6. Learn how case managers communicate with the physicians
   Note: It is important that we clarify and understand the role and activities of case managers within the context of the MEDS-AD program.
7. Examine the nature of communication in regards to recommendations
8. Inquire about follow-up procedures after recommendations are generated
9. Set up a face to face interview if possible after review of the paperwork is complete; rely on a telephone interview to obtain clarify information before a face-face interview is conducted.

B. Questions posed in the interviews
   1. Regarding communication between case reviewers and field pharmacists:
      - Are the case reviewers able to obtain the information needed from the field pharmacist and their photocopies of the medical records?
      - Is the correct information being photocopied?
      - What is the history of the medical records obtained? For example, is the patient's entire history in the past year being photocopied? Or just the last week/months?
   2. Regarding communication between case reviewers and MEDS-Ad physicians:
      - How are the recommendations being communicated to the MEDS-AD MD?
      - Is support of the recommendation through literature also supplied?
      - Are recommendations being misinterpreted?
   3. Regarding communication between MEDS-AD physicians and MEDS-AD recipient:
      - Are the MDs relaying the information to the patient?
      - Does the patient understand their change in therapy?
      - Are the MD's relaying changes in frequency and lifestyle to the patient?

The evaluators used the key informant technique in an effort to better understand program operations and challenges by speaking directly with the people who are in the best position to make these observations. The objective was to gather information that the evaluation team could use to formulate recommendations for program improvement.

A summary of findings regarding the MEDS-AD program is presented in the following table. The table is organized according to issues identified and suggestions emanating from the interview.

Issue	Background	Findings from Key Informant Interviews
Selection of enrollees for intervention	Initially the intervention was targeted at enrollees receiving more than 6 prescriptions per month.	Choosing enrollees who are high utilizers of prescribed drug services was the original intent. The strategy was revised beginning in April 2009 because choosing only high utilizers overlooked enrollees do not received needed medications or who are non-compliant with their prescribed drug regimens.
Notify prescribing provider	For those recipients selected for review. Medicaid staff will submit to the prescribing physician a letter and the medical records summary template requesting information necessary to conduct a case review. General information describing the review program and the prescribing physician's responsibility to respond within two weeks to the records summary request will be included. All prescribing physicians will be contacted. The letter includes contact information for any questions. A toll-free number will be provided for the practitioner to call with any questions	Physicians contacted for the key informant did not appear to know about the MEDS-AD program. Several times a specialist was contacted instead of the primary care provider.
Retrieval of patient medical records	Field pharmacists in the Medicaid Area Offices receive a list of selected recipients each month. The pharmacist seeks medical records from the physician(s).	Initially the field pharmacists visited the physician offices. If possible, to ask for photocopy information about MEDS-AD patients. The role of the field pharmacists dramatically changed as a result if the budget cuts in 2009. Visits to physician offices and pharmacies were curtailed. Due to limited contact with providers requests generally

		are faxed to the physician office, often to a medical secretary. If there is no response within a week, a second contact is made either by telephone or fax. If a physician office does not respond to a request, the field pharmacist may learn that they were given the wrong telephone number or that the doctor is a specialist who gas only seen the patient once or twice. If a problem is identified the field pharmacist obtains the correct information and contacts the health care provider. One field pharmacist reported checking patient records for completeness and pursuing more information if needed. One of the pharmacists often prepares a summary list of patient's disease states and medications before sending it to AHCA. The other field pharmacist asks that the records be sent directly to AHCA. Neither of the field pharmacists who were interviewed recall being asked to provide more information due to problems with legibility or to gather additional information requested by a clinical reviewer.
Requesting information from prescribing providers	Medicaid staff will make at least two follow-up phone calls to the prescribing physician if the requested medical information has not been received within the desired timeframe. In the event the prescribing physician is non-responsive, the vendor will report the prescribing physician to the Bureau of Pharmacy Services. If appropriate, the Bureau will refer	Both field pharmacists found physician's offices were usually very cooperative. They attributed this to their prior relationships with these offices and rarely encountered uncooperative physicians.

	the prescribing physician to the Medicaid Prescribing Pattern Review Panel.	
Independent review of cases	According to the initial program description. "Upon receipts of the requested recipient medical information from the prescribing physician, the vendor PharmD and vendor physician will jointly review the recipient's pharmacy history and medical summary and complete the case review document. The vendor will follow all state plan requirements including use of the state's preferred drug list, step therapy, prior authorizat5ions, and dosing limitations."	The pharmacists and physicians review information separately and have had no communication with one another. Reviewers did not recall receiving instructions about the state's preferred drug list, step therapy, prior authorization or dosing limitations. Informants suggested • Sharing comments from other reviewers or examples of ideal reviews • Giving reviewers feedback about their recommendations ; and • Telling reviewers when recommendations are implemented and whether they were beneficial to the patient.
Completed review packages	After all information needed is assembled, the reviewers will develop their proposed recommendations, which are then communicated to the treating provider via fax and mail. The provider is expected to follow up within five business days of notification of the reviewer's recommendations with and questions or changes implemented in the recipient's care plan. If no response is received from the provider Medicaid staff follows up via phone, fax, or mail until resolution and completion of the review. If	It appears that there is a problem in which specialists are contacted instead of the primary care providers. One reviewer estimated that 20-25% of patient records came from Specialists and not from Primary Care Physicians. This was a major concern since PCP notes are needed to get a complete picture of the patient. Also, specialty physicians may not benefit from recommendations that were meant for PCPs and not forwarded to the PCP. One reviewer was concerned about cases in which the primary care physician is not aware that a patient was taking prescription medications prescribed by other physicians.

	no change is indicated that is also documented in the recipient record in the database.	
Requested information and implementation of proposed recommendation	If changes are proposed or additional medical information is required, the prescribing physician is to respond within 72 hours for patient safety concerns, within 1 week regarding recommended changes to pharmacy regimen, and within 3 weeks for additional medical information that is requested.	The Agency was responsive to review concerns about patterns of narcotic use by notifying the patient's physician. Reviewers asked for additional data; only one recalled having received the missing information. At one time or another, all reviewers requested additional information that was missing in the patient records; only one reviewer reported that the additional information was promptly provided. Reviewers do not get feedback from the prescribing physicians or the Agency. Reviewers are not sure if their recommendations are implemented and do not know the outcomes of patients after recommendations are made.
Role of Field Pharmacists	Area office pharmacists follow up on the recommended changes (if any). In the event of a change necessary to protect the patient's safety, the prescriber is called and the area office pharmacist monitors to confirm that the change was made. In the event of non-compliance with requested actions for patient safety, prescribers may be referred to the Medicaid Prescribing Practice Review Panel, which may ultimately recommend termination of their prescribing for	The field pharmacists have not been asked follow up with physician about a patient, nor have they received information about the review or the resolution of any problems with a case. Field pharmacists were not clear about why the information was being collected and what happens to the information after it is collected.

	Medicaid patients.	
Prior Authorizations	For recipients with changes in their pharmacy regimens, Pharmacy Services will put edits or prior authorization requirements as needed to give enrollees immediate access to new medications or to prevent unauthorized prescription refills.	Clinical reviewers were not aware of this procedure. No reviewers expressed concern about an enrollee access to medication.
Tracking intervention cases	All pertinent dates (assignment of review, completion of review by pharmacist and physician, date any prescribing changes are recommended to physician, date of visits by the area office pharmacist for academic detailing) are recorded in a simple database for eventual use in the evaluation process. Medicaid staff documents the final recommendation to the recipient's records in the review database.	Physician information was not recorded in this database. Information about recommendations was not recorded in a consistent manner.

Hanlon JT, Schmader KE, Samsa GP, et al. A method for assessing drug therapy appropriateness. *Journal of Clinical Epidemiology* 1992: 45: 1045-51

Attachment III

Recommendations for MEDS-AD Program
Submitted June 18, 2010

Recommendations for MEDS-AD Program submitted to AHCA by the evaluation team on June 10, 2010. The recommendations offer suggestions to improve the

- timeliness and efficiency of program operations;
- benefits for providers and patients;
- the utilization and satisfaction of clinical reviewers, field staff and program operations staff.

Program Operations
1. Convene program participants for the purpose of minimizing the turn-around time for reviews including, but not limited to, processes associated with A. Identifying targets for review B. Obtaining information for review C. Communicating results of the review and obtaining provider response D. Assessing the impact on patient well-being and program cost
2. Prepare a program description that includes an organizational chart and a limited number of policies and procedures for the purposes of information sharing and program efficiency. Chart should include role of field pharmacists and reviewers.
3. Provide an overview of program operations to reviewers and staff so that each understands his or her role in the overall program.
4. Develop a procedure or algorithm to identify the primary care provider which increases the likelihood that A. Appropriate records are retrieved to conduct a productive review and generate useful recommendations B. Recommendations are conveyed to the appropriate provider who is in a position to evaluate the recommendation and take action when necessary.
5. Create a patient registry for monitoring high risk beneficiaries. This could be a modification of the current case tracking system with the objective of providing feedback to clinical reviewers and Medicaid while optimizing efficiency of program operations. A. Record death, transfer to institutional care and/or patient eligibility status B. Record responses to telephone inquiries C. Standardize (or record verbatim) the nature of reviewer recommendations D. Standardize recording of physician responses to support case follow-up process E. Specify criteria for a closed case.
Clinical Reviewers
6. Provide information needed by the reviewers and do not provide information of minimal value to the review process. A. Consider developing a checklist for physician offices naming data types of interest to accompany the medical records request such as recent laboratory reports and specialist consults. B. Develop a checklist for field pharmacists; describing activities they can implement including: verification of recipient eligibility; verification that identified provider is primary care physician of record; examination of medical records to ensure that records are not illegible due to poor quality of photocopying.

7. Evaluate the quality of the first ten reviews by each clinical reviewer and provide feedback for the purpose of improving the quality and completeness of the clinical review.

8. Schedule case conferences for reviewers to address recipients for which reviewers' recommendations were contradictory or substantially different

9. Follow-up on cases with reviewers. Share provider response, if any, accompanied by a summary of claims history for the 6 months period following the transmittal of reviewer recommendations.

10. Request input based on the experience of the clinical reviewers in refining program goals and objectives, setting expectations for outcomes of the review, expediting review of priority cases and referral including circumstances that are indicative of potential fraud or abuse.

Outside Evaluators

11. Systematically and in a timely fashion, compare the reviewer recommendations, provider response and claims history regarding
    A. Action is taken in response to any recommendations
    B. Claims records are consistent with intended response
    C. Any action taken in response is sustained (for example, recipient does not just consult another provider to circumvent any change in treatment regimen)
    D. Assess the effect of alternative communication strategies between AHCA and the providers for quality assurance and for program improvement.

    Specify a process for submitting any recommendations at prescribed intervals.

12. Investigate criteria for targeting patients who are the most likely to benefit from case review, e.g.,
    A. By disease; by severity of disease; by specific multiple-morbidity combinations
    B. Post-discharge from institutional setting

Modifications for Waiver Extension Phase

13. Provide opportunities for consultation among performing providers, reviewers and/or field pharmacists upon request.

14. Create a process by which a primary care provider, a clinical reviewer, or a field pharmacist can refer a patient for a more intensive MTM review; or to a program that incorporates proven disease management modalities:
    - a thorough patient evaluation
    - an inter-disciplinary team of providers
    - use of electronic medical record technology
    - deployment of home health technology (i.e., telehealth)
    - access to community-based support services that are sensitive to population needs and local systems of care.

    Appropriate referral options may include a care coordination program; a home and community based services waiver program; a Medical Home demonstration project; enrollment in a Managed Care Organization that serves special needs populations; and assignment of a patient case manager.

Attachment IV

Analysis of Paid Claims Data: Findings and Conclusions

The Florida Department of Children and Families (DCF) certifies persons eligible for MEDS-AD. Upon request of the Medicaid Pharmacy Bureau, DCF provided a list of all persons who had been certified for MEDS-AD from January 1, 2006 through September 30, 2009. Data analysts at AHCA then matched the list of eligibles to the Medicaid recipient enrollment file and to the paid claims file. All files were transferred to UF for review and analysis.

There are three eligibility categories within the MEDS-AD Program. This evaluation concerns persons in Medicaid Eligibility Group (MEG)1 only. It is important to note that at any point in time there will be individuals moving from one eligibility group to another.

It is also important to note that the state's fiscal intermediary changed on July 1, 2008. File configuration for the relevant administrative data changed along with the contractor. This fact provided its own set of challenges with identifying and retrieving the requisite data in addition to procuring a data analyst who could perform the task using the new vendor's software.

Multiple reconciliation strategies were applied to the data set to verify the inclusion of all recipients targeted for the MEDS-AD intervention and those included on the list of beneficiaries selected for a telephone survey regarding patient satisfaction with the MEDS-AD program. However, the results are subject to the limitations described.

Table 1. Total Prescriptions Claims Paid (average amount paid per beneficiary per month by date of service)[7]

	Pre-intervention Period Jan '06 – Sep '07 (21 months)	Intervention Period[8] Oct '07 – Dec '08 (15 months)	Post Intervention Period Jan '09 – Sep '09 (9 months)
MEDS-AD Letter Intervention Group	$523.33 (N=10796 Months, 603 unique individuals)	$731.05 (N=7734 Months, 647 unique individuals)	$802.41 (N=2900 Months, 413 unique individuals)
MEDS-AD Letter Intervention Control Group (N=700)	$241.77 (N=7997 Months, 536 unique individuals)	$353.34 (N=6356 Months, 560 unique individuals)	$417.56 (N-=3399 Months, 494 unique individuals)
All other MEDS-AD beneficiaries, ambulatory setting, not dual eligible (N=	$176.50 N=722016 Months, 65012 unique individuals)	$317.34 (N=363586 Months, 49978 unique individuals)	$327.41 (N+233507 Months, 44697 unique individuals)

Table 2. Other Paid Claims (average amount paid per beneficiary per month by date of service)

	Pre-intervention Period Jan '06 – Sep '07 (21 months)	Intervention Period Oct '07 – Dec '08 (15 months)	Post Intervention Period Jan '09 – Sep '09 (9 months)
MEDS-AD Letter Intervention Group (N=715)	$1147.29 (N=10796 Months, 603 unique individuals)	$1408.49 (N= 7734 Months, 647 unique individuals)	$1014.83 (N=2900 Months, 413 unique individuals)
MEDS-AD Letter Intervention Control Group (N=700)	$542.35 (N=7997 Months, 536 unique individuals)	$732.30 (N=6356 Months, 560 unique individuals)	$704.45 (N=3399 Months, 494 unique individuals)
All other MEDS-AD beneficiaries, ambulatory setting, not dual eligible (N=	$804.33 (N=722016 Months, 65012 unique individuals)	N=1278.75 (N=363586 Months, 49978 unique individuals)	$1354.53 (N=233507 Months, 44697 unique individuals)

[7] Includes all beneficiaries in the applicable group having ≥ 6 months of enrollment in the MEDS-AD program.
Excludes: beneficiaries enrolled in managed care plans; beneficiaries not matched in the eligibility and/or paid claims file (N=118?)

[8] Change in fiscal intermediary on July 1, 2008 with changes in recipient ID (from 9 to 1-digits), new file configuration and content.

Table 3. Total Paid Claims (average amount paid per beneficiary per month by date of service) [9]

	Pre-intervention Period Jan '06 – Sep '07 (21 months)	Intervention Period Oct '07 – Dec '08 (15 months)	Post Intervention Period Jan '09 – Sep '09 (9 months)
MEDS-AD Letter Intervention Group (N=715)	$1670.62 (N=10796 Months, 603 unique individuals)	$2139.53 (N=77347 Months, 647 unique individuals)	$1817.24 (N=2900 Months, 413 unique individuals)
MEDS-AD Letter Intervention Control Group (N=700)	$784.12 (N=7997 Months, 536 unique individuals)	$1085.63 (N=6356 Months, 560 unique individuals)	$1122.01 (N=3399 Months, 494 unique individuals)
All other MEDS-AD beneficiaries, ambulatory setting, not dual eligible (N=	$960.83 (N=722016 Months, 65012 unique individuals)	$1596.65 (N=363586 Months, 49978 unique individuals)	$1681.93 (N=233507 Months, 44697 unique individuals)

[9] Note: Data extraction and analysis were conducted in large part by Jianyi Zhang, Ph.D. His contributions are greatly appreciated