B-XIII. Disease Management

Part 1. Program Overview

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

The State launched a disease management initiative during 1998. The objective of the initiative was to determine if disease-specific care management could decrease Medicaid costs by improving the provision of preventative health care through educating beneficiaries suffering from a specific disease state, in addition to educating MediPass providers who deliver services to them. Approval was granted by HCFA (now known as CMS) to pursue limited disease management initiatives in April 1999. The State received approval to expand disease management programs to cover additional disease states in December 1999. The State contracted with vendors who specialized in managing specific disease states to provide specialized disease specific physician consultants, beneficiary and provider education, clinical practice guidelines and intensive care management focusing on preventative health care. The State has implemented programs to address the needs of beneficiaries living with the following disease states: asthma, diabetes, hemophilia, HIV/AIDS, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), hypertension, and end stage renal disease. Disease management services are provided to eligible beneficiaries enrolled in the MediPass program to improve medical self-management through the provision of preventative care management and educational activities.

The State selected Healthier Florida: Pfizer Health Solutions through a competitive procurement process and entered into a contract in January 2007 for a statewide comprehensive disease management program. The statewide disease management program enrolls eligible MediPass recipients with congestive heart failure, diabetes, sickle cell, chronic obstructive pulmonary disease, renal disease, hypertension, and asthma. AIDS Healthcare Foundation has provided an HIV/AIDS disease management program for Florida Medicaid since 1999. The State released a Request for Proposals (RFP) in August 2008 to competitively procure a new HIV/AIDS disease management contract.

A. Statutory Authority

1. Waiver Authority. The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act:

   ✓ 1915(b)(3) – The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the
Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

**1915(b)(4) –** The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

- **PAHP**
  The State assures it will comply with 42 CFR 431.55(f). The 1915(b)(4) waiver applies to this PAHP.

**2. Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act:

- **Section 1902(a)(1) – Statewideness** – This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

Disease management programs are available statewide to MediPass enrollees for all covered disease states.

- **Section 1902(a)(23) – Freedom of Choice** – This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State.

- **Section 1902(a)(10)(B) – Comparability of Services** – This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

- **Section 1902(a)(4) –** To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

The State seeks a waiver of 42 CFR 438.52 on choice of plans and 42 CFR 438.56 on enrollment for the Disease Management Programs.

**B. Delivery Systems**

1. **Delivery Systems.** The State will be using the following systems to deliver services:

- **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other
payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

X The PAHP is paid on a non-risk basis.

2. Procurement. The State selected the contractor in the following manner (required by 42 CFR Part 74 if contract over $100,000).

X Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

The State selected Healthier Florida: Pfizer Health Solutions, through a competitive procurement process and entered into a contract in January 2007 for a statewide comprehensive disease management program. The statewide disease management program enrolls eligible MediPass recipients with congestive heart failure, diabetes, sickle cell, chronic obstructive pulmonary disease, renal disease, hypertension, and asthma. The State continues to contract with AIDS Healthcare Foundation for HIV/AIDS disease management services. An RFP was released in August 2008 to competitively procure a new HIV/AIDS disease management contract.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

X The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

X The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries’ ability to access services.

Beneficiaries are able to access all medical services in a fee for service environment. Disease management program is available from the contracted vendor to individuals with identified diagnoses and who are enrolled in MediPass (PCCM).

The State seeks a waiver of 42 CFR 438.52 on choice of plans and 42 CFR 438.56 on enrollment for the Disease Management Programs.

2. Details. The State will provide enrollees with the following choices:
3. Rural Exception.

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii):

D. Geographic Areas Served by the Waiver Program

1. General. Please indicate the area of the State where the waiver program will be implemented.

   X Statewide

The State selected Healthier Florida: Pfizer Health Solutions, through a competitive procurement process and entered into a contract in January 2007 for a statewide comprehensive disease management program. The statewide disease management program enrolls eligible MediPass recipients with congestive heart failure, diabetes, sickle cell, chronic obstructive pulmonary disease, renal disease, hypertension, and asthma. The State continues to contract with AIDS Healthcare Foundation for HIV/AIDS disease management services.

2. Details. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

<table>
<thead>
<tr>
<th>City/County/Region</th>
<th>Type of Program</th>
<th>Name of Entity (for MCO, PIHP, PAHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide</td>
<td>PAHP</td>
<td>Healthier Florida: Pfizer Health Solutions Asthma, Diabetes, Hypertension, Congestive Heart Failure, Renal Disease, Chronic Obstructive Pulmonary Disease, Sickle Cell</td>
</tr>
<tr>
<td>Statewide</td>
<td>PAHP</td>
<td>AIDS HealthCare Foundation: HIV/AIDS</td>
</tr>
</tbody>
</table>
E. Populations Included in Waiver

1. Included Populations. The following populations are included in the Waiver Program:

   X__ Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

   ___ Mandatory enrollment
   ___ Voluntary enrollment

   X__ Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

   ___ Mandatory enrollment
   ___ Voluntary enrollment

   X__ Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

   ___ Mandatory enrollment
   ___ Voluntary enrollment

   X__ Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

   ___ Mandatory enrollment
   ___ Voluntary enrollment

   X__ Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

   ___ Mandatory enrollment
   ___ Voluntary enrollment

   X__ Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

   ___ Mandatory enrollment
   ___ Voluntary enrollment
X  TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children’s Health Insurance Program (SCHIP) through the Medicaid program.

X  Mandatory enrollment
___  Voluntary enrollment

The only exception to this is:
Beneficiaries enrolled in the Project AIDS Care Waiver are included in the AIDS disease management program. These beneficiaries include Medicare dual eligibles, a population otherwise ineligible for mandatory inclusion in disease management.

2. Excluded Populations. Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the “Aged” population may be required to enroll into the program, but “Dual Eligibles” within that population may not be allowed to participate. In addition, “Section 1931 Children” may be able to enroll voluntarily in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

X  Medicare Dual Eligible--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E)).

X  Poverty Level Pregnant Women -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

X  Other Insurance--Medicaid beneficiaries who have other health insurance.

X  Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

X  Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program.

___  Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

X  Participate in HCBS Waiver -- Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).
The only exception to this is:

Beneficiaries enrolled in the Project AIDS Care Waiver are included in the AIDS disease management program. These beneficiaries include Medicare dual eligibles, a population otherwise ineligible for mandatory inclusion in disease management.

___ American Indian/Alaskan Native--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ Special Needs Children (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

___ SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

X___ Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.

X___ Other (Please define):

Please note: Pursuant to the Special Terms and Conditions of the 1115 New MEDS AD Waiver, recipients eligible for Medicaid under the 1115 New MEDS AD Waiver will not be eligible for enrollment into any other waiver program including the 1915(b) Managed Care Waiver. MEDS AD recipients who would otherwise be eligible for enrollment in the approved 1915(b) Managed Care Waiver, under guidelines set forth by the waiver program design, will be able to receive the same services through the authority of the 1115 New MEDS AD Waiver in the same manner as those enrolled in the approved 1915(b) Managed Care Waiver.

F. Services

List all services to be offered under the Waiver program in Appendices C2.S. and C2.A of Section C, Cost-Effectiveness.

The Disease Management Program provides case management services. Disease management case management is currently for MediPass (PCCM) eligible beneficiaries meeting the criteria for the following disease states: AIDS, congestive heart failure, hypertension, diabetes, chronic obstructive pulmonary disease, sickle cell, renal disease and asthma.

1. Assurances.

X___ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).

Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.

Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable, and these contracts are effective for the period ____ to ____.

CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) -- prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) -- comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

   The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

The State will pay for all family planning services, whether provided by network or out-of-network providers.

Other (please explain):

Family planning services are not included under the waiver.

4. FQHC Services. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

The program is voluntary, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

The program is mandatory and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

The program is mandatory and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program.

5. EPSDT Requirements.

The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. 1915(b)(3) Services.

This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.
The disease management services are case management. Disease management case management is currently for MediPass eligible beneficiaries meeting the criteria for the following disease states: AIDS, congestive heart failure, hypertension, diabetes, chronic obstructive pulmonary disease, sickle cell, renal disease and asthma. These programs are available statewide and nurse care managers provide services. Payment is made to the contracted entity providing these services.

7. **Self-referrals.**

N/A The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:
Part 2. Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries’ access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services and these contracts are effective for the period _____ to _____.

• CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services and these contracts are effective for the period _____ to _____.

• CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.
The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care and these contracts are effective for the period ____ to ____.

- CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs.**

The following items are required.

a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan’s scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. ___ **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

c. ___ **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

d. ___ **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:
   1. ___ Developed by enrollees’ primary care provider with enrollee participation, and in consultation with any specialists’ care for the enrollee
   2. ___ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
   3. ___ In accord with any applicable State quality assurance and utilization review standards.

e. ___ **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee’s condition and identified needs.
Part 3. Quality

1. Assurances For PAHP program.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

These regulations apply only to the limited services provided by this PAHP.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, and these contracts are effective for the period ____ to ____.

- CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.
Part 4. Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

N/A The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

The State auto enrolls only MediPass recipients identified with specific diagnosis into a disease management program. These recipients are identified through MediPass claims data and then enrolled into a Disease Management program. Upon enrollment, these individuals are sent a notice informing them of their enrollment and provided 30 days opportunity to disenroll prior to contact by the Disease Management Program. These recipients can disenroll and/or re-enroll at any point in time. The Disease Management Programs do not market. These programs only contact MediPass recipients assigned to them by the State. Beneficiaries receiving PAC Waiver services may be referred to the HIV/AIDS Disease Management program by AIDS Service Organizations (ASOs) and may voluntarily enroll in the disease management program.

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities and these contracts are effective for the period ___ to ___.

- CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.

2. Details
a. Scope of Marketing

1. X The State does not permit direct or indirect MCO/PIHP/PAHP or PCCM marketing.

2. ___ The State permits indirect MCO/PIHP/PAHP or PCCM marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3. ___ The State permits direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.
The Provider may not use the data gathered from the program for marketing purposes or issue press releases regarding the program or data without the expressed prior written consent of the State. The State may authorize the Provider to issue press releases about the Provider’s services provided to the State and the outcomes from these services. The Provider agrees not to distribute such releases without the prior approval of final language by the State, in consultation with the provider.

b. Description. Please describe the State’s procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ___ The State prohibits or limits MCOs/PIHPs/PAHPs from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2. ___ The State permits MCOs/PIHPs/PAHPs and PCCMs to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. ___ The State requires MCO/PIHP/PAHP and PCCM to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

   The State has chosen these languages because (check any that apply):

   i. ___ The languages comprise all prevalent languages in the MCO/PIHP/PAHP/PCCM service area. Please describe the methodology for determining prevalent languages.

   ii. ___ The languages comprise all languages in the MCO/PIHP/PAHP/PCCM service area spoken by approximately ___ percent or more of the population.

   iii. ___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

   X ___ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

   ___ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements and these contracts are effective for the period ___ to ___.

   • CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.
2. Details.
   a. Non-English Languages

   X  Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

   The State defines prevalent non-English languages as:
   (check any that apply):
   1. X  The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”
   2. X  The languages spoken by approximately five (5) percent or more of the potential enrollee/enrollee population.
   3.   Other (please explain):

   X  Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

   As specified in the contract, “The Vendor is required to provide oral translation services (or services in other appropriate means) of information to any member who speaks any non-English language regardless of whether a member speaks a language that meets the threshold of a prevalent non-English language. The Vendor is required to notify its enrollees of the availability of oral interpretation services and to inform them of how to access oral interpretation services. The Vendor shall not charge the member for translation services.”

   ___  The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

   b. Potential Enrollee Information

   Information is distributed to potential enrollees by:

   ___  State
   ___  contractor (please specify) _

   X  There are **no potential enrollees** in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

   c. Enrollee Information

   The State has designated the following as responsible for providing required information to enrollees:

   (i) ___ the State
   (ii) ___ State contractor (please specify):________
   (ii) X  the MCO/PIHP/PAHP/PCCM
C. Enrollment and Disenrollment

1. Assurances.

___ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

X___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of these regulatory requirements for PIHP or PAHP programs. Please identify each regulatory requirement waived, the managed care program(s) to which the waiver will apply, and the State’s alternative requirement. (Please check this item if the State has requested a waiver of the choice of plan requirements in section B.I.C)

The State seeks a waiver of 42 CFR 438.52 on choice of plans and 42 CFR 438.56 on enrollment for the Disease Management Programs.

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements and these contracts are effective for the period ___ to ___.

- CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.

2. Details. Please describe the State’s enrollment process for MCOs/PIHPs/PAHP and PCCMs by checking the applicable items below.

a. Outreach. The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

b. Administration of Enrollment Process.

X___ State staff conducts the enrollment process.

___ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

___ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: __________________

Please list the functions that the contractor will perform:

___ choice counseling

___ enrollment
___ other (please describe):

**State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.**

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section B.I.E.

___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

___ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

   i. ___ Potential enrollees will have ____ days/month(s) to choose a plan.
   
   ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

X___ The State **automatically enrolls** beneficiaries

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item B.I.C.3)

X___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item B.I.C.1)

___ on a voluntary basis into a single MCO, PIHP, or PAHP, and beneficiaries can opt out at any time. Please specify geographic areas where this occurs: ____________

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

___ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

___ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**
The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

1. **Enrollee submits request to State.**
2. **Enrollee submits request to MCO/PIHP/PAHP/PCCM.** The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
3. **Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.**

The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee’s health care needs):

The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

The State **permits** MCOs/PIHPs/PAHPs and PCCMs to request disenrollment of enrollees. Please check items below that apply:

1. **MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:**
2. **The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.**
3. **If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the**
MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM’s caseload.

iv. The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. Assurances.

X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections, and these contracts are effective for the period ___ to ___

- CMS Regional Office approved the Pfizer contract and Amendment 1 in December 2007. The August 2008 RFP for HIV/AIDS disease management has been submitted to CMS.

X The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. Assurances for All Programs. States, MCOs, PIHPs, PAHPs, and States in PCCM programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
   b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
   c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

X The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

___ Please describe any special processes that the State has for persons with special needs.

1. Assurances.
The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits and MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulations, of a person described above.

**The prohibited relationships are:**

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP,
2. A person with beneficial ownership of five percent or more of the PCCM’s, MCO’s, PAHP’s, or PIHP’s equity,
3. A person with an employment, consulting or other arrangement with the MCO’s, PCCM, PAHP, or PIHP for the provision of items and services that are significant and material to the PCCM’s, MCO’s, PAHP’s, or PIHP’s obligations under its contract with the State.

The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.
Part 5. Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

- **Program Impact** (Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
- **Access** (Timely Access, PCP Capacity, Specialty Capacity, Coordination and Continuity of Care)
- **Quality** (Coverage and Authorization, Provider Selection, Quality Assessment and Performance Improvement, PCCM Quality)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring strategy may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the strategies used to monitor the major areas of the waiver. The second is a detailed description of each strategy.

**MCO and PIHP programs.** The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring strategies are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring strategies they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring strategies in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

### I. Summary chart

States should use the chart on the next page to summarize the strategies used to monitor major areas of the waiver program. If this waiver authorizes multiple programs, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Program Impact</th>
<th>Access</th>
<th>Quality</th>
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<tbody>
<tr>
<td></td>
<td>Choice</td>
<td>Marketing</td>
<td>Enroll Disenroll</td>
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<tr>
<td>Accreditation for Deeming</td>
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<tr>
<td>Accreditation for Participation</td>
<td>X</td>
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<tr>
<td>Consumer Self-Report data</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Data Analysis (non-claims)</td>
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<td>Enrollee Hotlines</td>
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<tr>
<td>Focused Studies</td>
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<tr>
<td>Geographic mapping</td>
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<td>Independent Assessment</td>
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<tr>
<td>Measure any Disparities by Racial or Ethnic Groups</td>
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<tr>
<td>Network Adequacy Assurance by Plan</td>
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<td>Ombudsman</td>
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<td>On-Site Review</td>
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<td>Performance Improvement Projects</td>
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<tr>
<td>Performance Measures</td>
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<tr>
<td>Periodic Comparison of # of Providers</td>
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<td>Profile Utilization by Provider Caseload</td>
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<tr>
<td>Provider Self-Report Data</td>
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<td>X</td>
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<tr>
<td>Test 24/7 PCP Availability</td>
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<td>Utilization Review</td>
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<td>Other: (describe)</td>
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</table>
II. Monitoring Strategies

Please check each of the monitoring strategies or functions below used by the state. A number of common strategies are listed below, but the state should identify any others it uses. If federal regulations require a given strategy, this is indicated just after the name of the strategy. If the state does not use a required strategy, it must explain why.

For each strategy, the state must provide the following information:
- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of strategy
- Frequency of use
- How it yields information about the area(s) being monitored

a. ____ Accreditation for Deeming (i.e. the State deems compliance with certain access, structure/operation, or quality requirements for entities that are accredited)
   ___ NCQA
   ___ JCAHO
   ___ AAAHC
   ___ Other (please describe)

b. ____ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)
   X NCQA
   X JCAHO
   ___ AAAHC
   X Other (please describe)

Applicable Program: PAHP
Personnel responsible: PAHP and State Agency Staff
Detailed Description: The Agency for Health Care Administration requires DMOs that respond to competitive procurements for disease management services to be accredited for their disease management program by at least one entity (e.g., NCQA, the Joint Commission, URAC). The current DMOs under contract with the Agency, AIDS Healthcare Foundation and Pfizer Health Solutions (and subcontractor McKesson Health Solutions) have certification and accreditations for Disease Management from NCQA.
Frequency of Use: State requires the vendors to maintain accreditation and submit certification of renewal to the Agency.

c. ____ Consumer Self-Report data
   ___ CAHPS (please identify which one(s))
   ___ State-developed survey
   ___ Disenrollment survey
   ___ Consumer/beneficiary focus groups
   X Other
Applicable Program: PAHP
Personnel responsible: PAHP and State Agency Staff
Detailed Description: Pfizer Health Solutions contracts with an external vendor to conduct patient satisfaction surveys annually. The results of these surveys are presented to AHCA. AIDS Healthcare Foundation conducts patient satisfaction surveys of its beneficiaries and provides the results to AHCA.
Frequency of Use: Annually.

- X Denials of referral requests
- Disenrollment requests by enrollee
- From plan
- From PCP within plan
- Grievances and appeals data
- PCP termination rates and reasons

Applicable Program: PAHP
Personnel responsible: PAHP and State Agency Staff
Detailed Description: The vendors track and report complaints and issues to the Agency. Agency staff review and follow up on complaints and issues as necessary. Frequency of Use: The PAHP reports to the Agency on a monthly basis and as needed.

e. Enrollee Hotlines operated by State
f. Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).
g. Geographic mapping of provider network
h. Independent Assessment of program impact, access, quality, and cost-effectiveness (Required for first two waiver periods)
i. Measurement of any disparities by racial or ethnic groups
j. Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]
k. Ombudsman
l. On-site review
m. Performance Improvement projects [Required for MCO/PIHP]
n. X___ Performance measures [Required for MCO/PIHP]

X___ Process
X___ Health status/outcomes
   Access/availability of care
X___ Use of services/utilization
   Health plan stability/financial/cost of care
   Health plan/provider characteristics
X___ Beneficiary characteristics

Applicable Program: PAHP
Personnel responsible: PAHP and State Agency Staff
Detailed Description: The vendors provide regular reports to the Agency (some weekly, some monthly, some quarterly and annual) on process measures such as number of beneficiaries contacted and enrolled, number of baseline and milestone assessments completed, etc. Quarterly and annual reports include self-reported patient health status and outcome measures. The vendors also use claims data to report on patients’ health care utilization (e.g., ED visits, inpatient visits and length of stay, outpatient visits, pharmacy utilization).
Frequency of Use: Quarterly and Annually submit reports to the Agency.

o. _____ Periodic comparison of number and types of Medicaid providers before and after waiver
p. _____ Profile utilization by provider caseload (looking for outliers)
q. X___ Provider Self-report data
   X___ Survey of providers
   ___ Focus groups

Applicable Program: PAHP
Personnel responsible: PAHP and State Agency Staff
Detailed Description: The vendors conduct provider satisfaction surveys, either through their own organization or through contract with an external vendor. Results are reported to the Agency.
Frequency of Use: Annually.

r. _____ Test 24 hours/7 days a week PCP availability
s. _____ Utilization review (e.g. ER, non-authorized specialist requests)
t. _____ Other: (please describe)
Part 6. Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State’s Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an initial waiver request. The State assures that it will conduct the monitoring strategies described in Section B, and will provide the results in Section C of its waiver renewal request.

X This is a renewal request. The State provides below the results of monitoring strategies conducted during the previous waiver.

For each of the strategies checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each strategy. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each strategy identified in Section B:
b. Strategy: Accreditation for Participation

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of results: The two DMOs with whom AHCA has contracted to provide disease management programs have active accreditation/certification from NCQA for disease management. Pfizer Health Solutions has Program Design and Systems Certification for Asthma, Cardiovascular Disease, COPD, Diabetes, and a Pregnancy Program. Pfizer’s main subcontractor, McKesson Health Solutions, has Patient and Practitioner Oriented Accreditation for Diabetes, Asthma, CHF, COPD, and Coronary Artery Disease. AIDS Healthcare Foundation has Patient and Practitioner Oriented Accreditation for HIV/AIDS.

Problems identified: None.

Corrective action (plan/provider level): None.

Program change (system-wide level): None.

c. Strategy: Consumer Self-Report Data

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of results: Patient satisfaction surveys were conducted in 2007 and 2008 for the HealthierFlorida program. 1000 beneficiaries were surveyed. Approximately 90 percent of care managed beneficiaries said they would recommend the program to a friend or family member. Nearly two-thirds of respondents said that they are more confident about taking care of their health problems as a result of participating in the program. Over 90 percent of respondents rated the HealthierFlorida program as Good, Very Good, or Excellent.

Problems identified: None.

Corrective action (plan/provider level): None.

Program change (system-wide level): None.

d. Strategy: Data Analysis (non-claims)

Confirmation it was conducted as described:

_X_ Yes

___ No. Please explain:

Summary of results: The DMOs track complaints and issues on a regular basis and provide these to AHCA contract managers. AHCA staff review these issue logs and follow-up as necessary. For the most part, the calls that the DMO staff receive are about issues with getting their health care rather than complaints about the disease
management program. DMO-related calls and issues are generally requests for DMO staff to mail additional educational materials to the beneficiary.

Problems identified: None.

Corrective action (plan/provider level): None.

Program change (system-wide level): None.

n. Strategy: Performance Measures

Confirmation it was conducted as described:

☑ Yes
☐ No. Please explain:

Summary of results: The DMOs report on process measures such as the number of beneficiaries contacted and assessed on a weekly and/or monthly basis. These reports are reviewed by the AHCA contract manager to ensure that the DMO is on track regarding the number of beneficiaries that have access to the program and are being actively care managed. As of September 2008, the HIV/AIDS DMO had completed assessments for 85% of its eligible beneficiaries. As of October 2008, the Pfizer Health Solutions HealthierFlorida program has over 11,000 beneficiaries who are currently being actively managed or have an assessment in progress. The HealthierFlorida nurse care managers are at 100% of their capacity in terms of the established care manager-to-beneficiary ratio. The DMOs report on patient self-reported health status and outcome measures on a quarterly and annual basis. The most recent quarterly report from the HealthierFlorida program is on quarter two of 2008. Improvements between baseline and most recent follow-up are reported in the percentage of beneficiaries who report exercising and not smoking, and medication compliance appears to have improved. Quarterly and annual reports including claims analysis for the disease management programs are pending as claims data for the 2007 calendar year are being validated.

Problems identified: None.

Corrective action (plan/provider level): None.

Program change (system-wide level): None.

q. Strategy: Provider self-report data

Confirmation it was conducted as described:

☑ Yes
☐ No. Please explain:

Summary of results: Provider satisfaction surveys are currently being fielded for the disease management program. In 2006, the Agency received Provider Satisfaction survey results for the 2005 period in the Florida: A Health State program (which ended in December 2006). Of the providers surveyed, over 80% reported that they would
recommend the disease management program to other physicians, and 88% reported that they would recommend the program to their chronically ill patients.

Problems identified: None.
Corrective action (plan/provider level): None.
Program change (system-wide level): None.