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June 30, 2020

**VIA ELECTRONIC SUBMISSION**

Mary C. Mayhew, Secretary  
Beth Kidder, Deputy Secretary  
Agency for Health Care Administration  
FLMedicaidWaivers@ahca.myflorida.com

Re: Florida's Request for a Two-Year Extension of the 1115 Managed Medical Assistance Waiver.  
(Project Number 11-W-00206/4)

Dear Secretary Mayhew and Deputy Secretary Kidder,

Florida Policy Institute (FPI) submits these comments in response to the Agency for Health Care Administration's (AHCA's) request to seek a two-year extension of the 1115 Managed Medical Assistance (MMA) waiver. FPI is an independent, nonpartisan, and nonprofit organization dedicated to advancing policies and budgets that improve the economic mobility and quality of life for all Floridians. We are committed to public policies which ensure that all Floridians have access to quality affordable health care.

Facing an unprecedented economic downturn and state budget crisis, transparency and accountability on how precious Medicaid dollars are spent is more important than ever. Further, with COVID-19 starkly laying bare deep disparities in health and health care among Floridians, it is time for the state to take bold action to address these longstanding problems. The MMA program, a demonstration project intended to test new and innovative strategies, provides a unique opportunity to do so.

Florida is proposing to extend its existing MMA 1115 demonstration two years before its expiration. We believe that this early request necessitates explicit additional state commitments and actions to address health disparities and provide more transparency and accountability in the Medicaid program. Specifically, we recommend that AHCA take the following action steps, as detailed in the comments below:

- Collect and publish Medicaid performance measure data disaggregated by race/ethnicity and include COVID-19 measures
- Reinstate the requirement for managed care plan cultural competency plans
- Report Child Core Set performance measures

- Withdraw the request for a two-year extension of the elimination of retroactive Medicaid eligibility coverage
- Provide evidence of increased access to health care through expansive benefits
- Include adult vaccinations as mandatory benefits rather than optional expansive benefits

### **Collect and publish Medicaid performance measure data disaggregated by race/ethnicity**

Experts agree that "[\[t\]o reduce disparities, it is critical to first know where they exist.](#)" The COVID-19 pandemic has highlighted gaps in the collection and publication of health-related race/ethnicity data. An earlier [FPI report](#) urges the state to take additional steps for answering the critical question: *Does Florida's Medicaid program help reduce health disparities?*

[Thirty-four percent of Medicaid enrollees are Hispanic and 26% are Black.](#) For the most part, they are enrolled in managed care plans (MCOs). As part of its oversight responsibilities, AHCA collects and publishes data on how well MCOs are meeting certain "[performance measures.](#)" These include measures such as access to preventive care, controlling high blood pressure, medication management for people with asthma, and hospital readmissions.

[Florida Department of Health data](#) already show that Floridians of color experience higher rates of illness and death from a number of health conditions, including heart disease, stroke, specific cancers, diabetes, HIV/AIDS, mental health, and asthma. It is critical for policymakers and the public to know whether the Medicaid program is helping to reduce these disparities.

We applaud the agency in taking steps to disaggregate performance data based on race/ethnicity and other demographic factors through its [Quality Initiatives dashboard.](#) This will help gauge the effectiveness of MMA pilot projects to reduce potentially preventable healthcare events and improve birth outcomes.

We urge AHCA to extend this framework for collection and publication of MCO performance measures. Multiple [other states are already doing this](#) for monitoring health disparities in their Medicaid programs, as well as the federal Centers for Medicaid and Medicare Services (CMS) for [Medicare Part C plans.](#) Notably, the largest Florida Medicaid MCOs are already participating in the Part C program.

Moreover, at this moment, it is critical for AHCA to develop some specific COVID-19 performance measures and require that data on these measures also be disaggregated by race and ethnicity. State data shows that [coronavirus rates in Florida are twice as high in Black and Hispanic communities.](#)

New Florida [Medicaid policies](#) specify that the program covers all medically necessary services required to facilitate testing and treatment of COVID-19. But the state cannot effectively gauge whether communities of color are benefiting from these policies. Nor can meaningful interventions be implemented to reduce disparities without this data. Also, this type of information will be vitally important when a vaccine becomes available for monitoring equitable distribution to communities of color.

### **Reinstate the requirement for cultural competency plans**

Until August 2018, [AHCA had incorporated specific terms in plan contracts](#) to help address racial, ethnic and language disparities. They required managed care plans (MCOs) to develop cultural competency plans (CCPs) to "ensure that services are provided in a culturally competent manner to

all enrollees, including all services and settings and including those with limited English proficiency.” Contract terms further specified details of what was to be included in these plans and a requirement for an annual evaluation, including analysis of successes and challenges in meeting previous year goals and objectives. In prior years, AHCA's [External Quality Review Organization](#) also provided recommendations on how MCOs could strengthen their CCPs and MCO contract terms to address disparities. These included the use of race, ethnicity, and language data for program evaluation. However, for unknown reasons, [the requirement that each MCO develop a CCP and annual evaluation was removed from the MCO contract effective August 1, 2018.](#)

Restoration of cultural competency plans as prescribed in earlier MCO contracts are an essential step to reduce health disparities and ensure transparency and accountability in the program.

### **Report Child Core Set performance measures**

Florida already reports to federal CMS on multiple child core set (CCS) measures. Yet performance measure data included in the waiver request excludes those CCS measures which do not overlap with Health Effectiveness Data Information Set (HEDIS) measures. The attached analysis by Tricia Brooks, a research professor with Georgetown Center for Children and Families, provides a detailed comparison of the two sets of measures. It includes the following key findings:

The data included in the waiver request on performance measures is incomplete because it does not include all the CCS measures reported to CMS – just those that overlap with NCQA HEDIS measures. Reporting only the HEDIS measures gives the appearance that overall performance on child health measures is better than it is.

By evaluating MCO performance only on HEDIS measures, MCOs are not measured and held accountable for other critical areas of child health (e.g., developmental screenings for children under age 3, a CCS measure on which the state ranked in the bottom tier for calendar year 2016 data (2017 CCS)).

Evaluating performance by comparing MCO rates to the national Medicaid HEDIS mean only identifies whether the state/MCO is an average performer, above average or below average. The CCS data provides specific rates for each measure for each reporting state, providing a better representation of where a state falls within the range of rates across all reporting states.

It is also important to note that federal law will require reporting to CMS of all CCS measures in federal fiscal year 2024. This will occur prior to the end of the two year extension period. We recommend that the waiver extension request include provisions on how the state intends to implement these new requirements.

### **Withdraw the request for a two year extension of the elimination of retroactive Medicaid eligibility coverage**

The public notice document rehashes old policy justifications for the retroactive Medicaid eligibility coverage (RME) cut. They are as disingenuous today as they were when originally included in the

state's initial waiver amendment request. [FPI's comments](#) submitted to the federal government at that time — May 2018 — are equally relevant to this waiver extension request.

This cut particularly hurts uninsured Floridians hit with unanticipated and costly illnesses, such as stroke, cancer, and accidents. Without RME, these individuals will likely face enormous hospital and other medical bills.

["George's" story](#) is a tragic real life example of the how this policy change is playing out. In late January 2020, George suffered a heart attack and was rushed to the hospital. The paperwork for his Medicaid coverage was filed in February. Because his application had not been submitted during the month of his hospitalization, he received a bill for \$62,000 — a heavy additional financial burden and stressor during the time he has been trying to recover. Before elimination of retroactive coverage, individuals and their families in the middle of a medical crisis had a 3-month cushion of time to file a Medicaid application.

This policy change is even more harsh in a non-expansion state like Florida. Notably here, most healthy, uninsured, low-income Floridians will not qualify until they are seriously ill or disabled. Eliminating RME makes their plight even worse. While RME is limited and short-term, it is at a crucial time when people are likely to need costly medical services. Taking away this coverage is cruel, arbitrary and has no sound policy basis.

Moreover, during the 2020 session the Legislature opted not to make this cut permanent. Instead, in HB 5003, the 2020-21 appropriations implementing bill, this cut was only temporarily extended through June 30, 2021. AHCA was also directed to submit a report to the governor and Legislature by March 1, 2021, on the impact of this cut on beneficiaries and providers. Without this information, the Legislature clearly did not want to take action to make this cut permanent. Thus, AHCA's waiver request to extend this cut through June 30, 2024, is without legislative authority.

### **Provide evidence of increased access to health care through expansive benefits**

We applaud the agency for negotiating with the plans to obtain “the most robust expanded benefit packages since the inception of the program.” AHCA states that “expanded benefit offerings have improved the array of services available to Medicaid recipients and enhanced recipient access to care.”

However, there is no evidence that beneficiaries are in fact accessing these benefits and to what extent. How is the agency gauging whether the plans are providing anything of significant value to beneficiaries through their expanded benefits package?

### **Include adult vaccinations as mandatory benefits rather than optional expansive benefits**

We are troubled that adult vaccinations are only offered through the expanded benefit package. As an “expanded benefit” the agency cannot hold plans accountable for providing this essential component of adult preventive care, which is particularly important during this pandemic. Health experts are already warning that the influenza vaccination rate needs to substantially increase “[to mitigate a potentially deadly confluence of seasonal influenza with an anticipated second wave of COVID 19.](#)” Notably, the [Centers for Disease Control](#) recommends a flu vaccine for every adult.

The [Centers for Disease Control](#) further states: "...ensuring that routine vaccination is maintained or reinitiated during the COVID-19 pandemic is essential for protecting individuals and communities from vaccine-preventable diseases and outbreaks. Routine vaccination prevents illnesses that lead to unnecessary medical visits, hospitalizations and further strain the healthcare system. For the upcoming influenza season, influenza vaccination will be paramount to reduce the impact of respiratory illnesses in the population and resulting burdens on the healthcare system during the COVID-19 pandemic."

Florida Medicaid needs to do its part. We urge the agency to include adult vaccinations as part of the mandatory package of services offered by MCOs, just as it does for childhood/adolescent vaccines and to monitor plan performance in providing these vaccines.

### **Conclusion**

Thank you for the opportunity to submit these comments and please feel free to contact us if you need additional information or have questions.

Sincerely,

/s/ Anne Swerlick

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To: Interested Parties  
From: Tricia Brooks, Georgetown University Center for Children and Families  
Re: Review of Florida Medicaid Quality Reporting for Children  
Date: June 22, 2020

This memo summarizes a review and comparison of Florida's reporting on the Child Core Set (CCS) of Medicaid and CHIP health care quality measures with the quality measurement reporting included in Florida's Medicaid Section 1115 waiver extension request. Please note that this memo compares only the measures reported in the waiver extension request that are also included in the CCS.

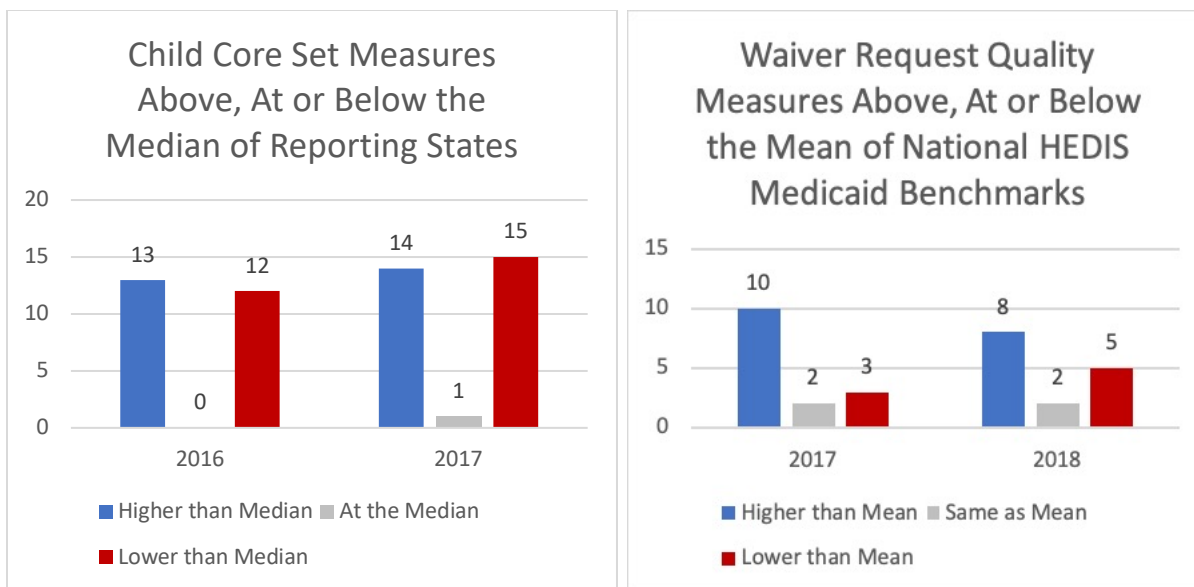
Key findings of this analysis:

- The data included in the waiver request on performance measures is incomplete because it does not include all of the CCS measures reported to CMS – just those that overlap with NCQA HEDIS measures. Reporting only the HEDIS measures gives the appearance that overall performance on child health measures is better than it is.
- By evaluating MCO performance only on HEDIS measures, MCOs are not measured and held accountable for other critical areas of child health (e.g., developmental screenings for children under age 3, a CCS measure on which the state ranked in the bottom tier for calendar year 2016 data (2017 CCS)).
- Evaluating performance by comparing MCO rates to the national Medicaid HEDIS mean only identifies whether the state/MCO is an average performer, above average or below average. The CCS data provides specific rates for each measure for each reporting state, providing a better representation of where a state falls within the range of rates across all reporting states.

### **How Florida's CCS Data and the HEDIS Data Compare**

*Reporting only HEDIS measures in the waiver request suggests that the state performs better overall on children's quality of care than the CCS reporting reflects.* The charts that follow summarize these topline results:

- Florida reported 25 CCS measures for which we have state-level data (CMS publishes the individual state data only if at least 25 states report a measure). Of the 25 measures reported by Florida for the 2017 CCS (2016 calendar year service data), 13 were higher than the median and 12 were lower than the median. For the 2018 CCS (2017 calendar year service data), 14 measures were higher than the median, 1 measure was at the median, and 15 measures were lower than the median.
- The waiver request reports only 15 HEDIS measures that align with the core set. Of those, 10 measures were above the mean, 2 measures were at the mean, and 3 measures were lower than the mean for the 2017 CCS. For the 2018 CCS, 8 measures were above the mean, 2 measures were at the mean, and 5 measures were lower than the mean.



### The Child Core Set Measures Critical Aspects of Child Health Quality Not Measured by HEDIS

The CCS was enacted as part of the Children’s Health Insurance Program (CHIP) Reauthorization Act of 2019. The initial child core set was developed with the input of a broad and diverse group of child health experts and stakeholders in collaboration with CMS; it is reviewed and updated annually through a similar process. As such, CMS and child health stakeholders agree that HEDIS does not represent the breath of child health quality that should be measured and improved. For example, of 25 core measures in the 2017 CCS, two-thirds (18 measures) come from HEDIS while one-third (9 measures) come from other measurement sources. The nine non-HEDIS measures include key measures such as development screenings in children under age 3, low-weight births, child and adolescent suicide risk assessment. (Note: There are also child and adolescent health measures in HEDIS that are not included the CCS.)

### Evaluating Performance Based on National Averages Sets a Low Bar

HEDIS publicly reports the national mean (average) rate across all reporting plans in three or four categories: commercial HMO, commercial PPO, commercial HMO/PPO, and Medicaid HMO. The CCS reports data based on the median (middle value).

Comparing quality to the mean only reflects if the state’s performance is average, better than average, or lower than average. Often states establish the HEDIS mean as the standard that managed care plans are expected to meet. Doing so sets a fairly low bar for performance standards and doesn’t provide transparency in areas where there is very low or very high performance. To overcome these inadequacies, CMS categorizes performance on the core set in quartiles and specific CCS rates reported by all states on each measure.

State-level rates provide a better way to compare a state or individual plan’s performance to the range of reported rates across states. It allows for states to compare their performance to other states that may have similarities in populations served, geographic location, or other demographics. Averages cannot provide the kind of insight that understanding where a state or plan’s performance falls within the range does. It doesn’t tell stakeholders how much

improvement may be possible, or which states are leaders and can offer insights on ways to improve quality.

**Conclusion**

Evaluating the comparing the state’s performance to national averages provides an incomplete picture of the quality of health care children, pregnant women, and poor parents receive in Medicaid. A more thoughtful assessment of the state’s performance

**Background and Additional Detail**

The remainder of this memo provides background and a more detailed description of the differences in the benchmarks and reporting between the two sets of data, which is summarized in this table.

	Service Reporting Period (Calendar Year)	Comparison Data Source	Mean or Median Used?
Florida Reporting on Child Core Set	2016, 2017	Number of states reporting each measure to CMS	Median (middle value)
HEDIS Quality Measures Reported in the Waiver Request	2017, 2018	Medicaid Managed Care Plans Reporting to NCQA	Mean (average value)

Description of the reporting on the child core set

States voluntarily report child core set quality measures annually. In turn, CMS publishes state-level data on each measure if at least 25 states report it. The number of states reporting each individual measure ranges from 25 to 51; thus, the comparison does not always provide a complete national comparison.

Looking at the highest and lowest rates provides the range of performance across states. If the range is small, as it is in reporting access to primary care providers (PCPs), then there may be little room for improvement. For example, access to PCPs for children, ages 12-24 months, ranges from a low of 87.9 to a high of 98.1, with a median of 95.7. If a state is above the median, there is not as much room for improvement as there is if the state are at the bottom of reporting states. In contrast, childhood immunizations combination 3 range from a low of 6.1 to a high of 80.8, with a median of 69.5. Where a state falls in the range matters as much if not more than whether they are above or below the median.

The CCS data used for comparison were published in the CMS annual quality reports released in 2018 and 2019. However, the data lag should be noted. The 2019 report publishes data submitted for the 2018 core set based on for 2017 service data. Likewise, the 2018 report publishes data on the 2017 core set for the 2016 service year. (Yes, this is confusing!)

Florida reporting of quality measures in Section 1115 waiver extension request

HEDIS provides a comparison to a composite of all nationwide Medicaid plans that report HEDIS measures to NCQA for accreditation purposes or if the state requires it. As noted above, two-



thirds of quality measures in the child core set are NCQA HEDIS measures. For these measures, Florida compares the state's rate to the national Medicaid HEDIS mean – not the median reported by states to CMS on the child core set.

The quality data embedded into the waiver request includes footnotes but the citations were excluded. The state provided the source document, including the footnotes, and reflects that FL CY 2017 data is compared to CY 2015 HEDIS benchmarks. Likewise, the FL CY 2018 data is compared to CY 2016 HEDIS benchmarks. Although more recent HEDIS averages are available, it is unclear why the state compared its data to two-year old HEDIS benchmarks. If the national averages are improving, the state performance in comparison may be lower than reported. At the same time, if the national averages are declining, the state performance may appear to be higher than reported.

#### What does the data lag mean in comparing the two data sources?

The CCS data reported in FY 2018 annual report for the 2017 CCS aligns with the waiver CY 2017 reporting. The state's CCS data for CY 2018 has not yet been published by CMS. Thus, we are only able to compare the actual data points for service year 2017.

#### How do the rates reported in the two sets of measures compare?

The 2018 CCS data (for calendar year 2017 data) is for the same service year as the CY 2017 data reported in the waiver request. The data points reported in both sets are generally consistent. However, the waiver data is reported in whole numbers, while the CCS data uses a single decimal point. Most data points round up with the exception of four discrepancies:

- The rate for “well-child visits in the first 15 months of life” rounds down. The CCS data point is 69.5 but the waiver request point is 69.
- For “children prescribed ADHD meds during the maintenance phase,” the CCS data at 63.2 was reported in the waiver data as 64.
- For “chlamydia screening in women 16-20 years,” the CCS data point is 61.0 but is reported as 62 in the waiver request.
- For “use of first-line psychosocial care for children and adolescents on antipsychotics,” CCS data point is 60.7 but is reported in waiver request as 62.

#### In comparing year over year, what level of improvement is seen in the two sets of data?

The number of measures on which Florida shows improvement are similar but not consistent when comparing performance from one year to the next. For the CCS measures that align with reported HEDIS measures, the state shows improvement on 9 measures, no change on 1 measure, and a decline on 4 measures. (One measure – Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – was not reported for the 2017 CCS (2016 service year). In the waiver data, the state shows improvement on 8 measures, no change on 4 measures, and a decline on 3 measures. While showing improvement from year to year is important, the lack of comparative data does not allow stakeholders to fully assess the state's potential for improvement across the quality spectrum.