Data Book FAQ

Response to Data Dook Inquiries

#	Question/Comment	Response
1	Does SMMC insurance plans lack of empaneling Medicaid credentialed non-physicians as primary care providers (NP's and PA's) affect cost of access to LTC and MMA care?	This type of analysis is not included in the data book.
2	Does actuarial data include analysis of encounters by provider types (i.e., Physician, PA, NP)?	This type of analysis is not included in the data book.
3	Are value based outcomes of providers by type (i.e., Physician, PA, NP) used to compare cost of services by ICD diagnostic codes and average length of time recipients receive specific LTC and MMA services?	This type of analysis is not included in the data book.
4	Will the capitated rates be based on a bid/negotiated process as part of the ITN or will capitated rates be set in advance of the ITN and bidding MCO's agree to accept the pre-determined actuarial sound rates as set forth? Said another way, are the capitated rates negotiated in any way between the MCO's and the State for the ITN or in subsequent years of the contract?	The Agency can not respond at this time.
5	Are children with special healthcare needs that qualify for Medicaid required to join the Children's Medical Services Network?	No, children with special healthcare needs are allowed to join any plan in their region.
6	Will the Children's Medical Services Network continue to be paid on a managed fee-for-service basis?	Children's Medical Service Network will be paid per 391.045 (1), F.S.
7	Can you please go into more detail about what exactly is included in the CMSN data? For example, is it a combination of both the data for the kids in that specialty plan plus kids who would qualify but chose another MCO?	The data book includes a CMSN Delivery System section which includes only data for children enrolled in CMSN. These children could choose at a later date to join another Medicaid plan in their region, in which case they would no longer be classified as part of the CMSN Delivery System. Conversely, children classified as "children with special healthcare needs" and enrolled in another MMA plan could choose to join the CMSN Delivery System at a later date.
8	Please clarify how the "transition percentage" will be applied to the rates. Will 3% be applied as an average shift across all months or will the "transition percentage" be phased-in over the rate year and end at 3%? If there is no phase-in, please confirm that a plan would have to transition 6% in a rate year to average out to 3% across all months.	The Agency can not respond at this time.
9	Could you please provide historical enrollment by month by HCBS vs. Non-HCBS for the LTC program since inception?	This information can be found on AHCA's website: http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml
10	Could you please provide the utilization data for the LTC data book in addition to the costs provided?	Service utilization reporting is not consistent across time periods and MCOs. The most reliable utilization data available is for nursing facility and hospice, which is already included in the data book.
11	Could you please provide more information on methodology and assumptions that will be used to project the data book forward to the rate year to determine rates?	The Agency can not respond at this time.
12	Will any IBNR be included in the final base data that is used for rates?	The Agency can not respond at this time.
13	For the potential "New Waiver" populations could you please provide member counts and accompanying utilization and cost data?	This information will be provided after rate negotiations. The Agency will adjust the final negotiated rates to reflect the impact of these items as necessary.
14	Could you please provide more information on the "Express Enrollment" population, including member counts and accompanying utilization and cost data?	The Agency can not respond at this time.
15	Since Oct 2015, we have noticed steady increase in Medically Fragile members. Will you be adjusting the base data for the increase of these memebrs?	The data book includes historical information only.
16	There was a change in the HIV algorithm effective Sep 2016. Neither the Program Changes in Exhibit M-15 or Section IV of the narative are listing this change as an adjustment to the base data. Will you be able to provide adjustment factors for each of the base data exhibits?	The data book reflects the new HIV/AIDS identification algorithm, therefore no further adjustment is needed.
17	Are there any known issues with AHCA eligibility data (in comparison to the MMA Capitated Plan data)?	Milliman is not aware of any issues at this time.
18	HIV/Aids eligibility criteria was recently changed. Does the data book reflect the new criteria?	The data book reflects the new HIV/AIDS identification algorithm, therefore no further adjustment is needed.
19	Child welfare is not split SMI/non-SMI? Why?	The Agency has not historically paid different capitation rates for SMI vs. non-SMI members in the Child Welfare rate group.
20	Could rate cells in Figure 2 be changed for the upcoming re-procurement? For example, is there any chance that CMSN will be a separate rate cell going forward?	The Agency can not respond at this time.
21	What is the algorithm to determine the Children with Special Health Care Needs?	This population is defined as children under age 21 whose serious or chronic physical or developmental conditions require extensive preventive and ongoing care. We used the list of June 2016 members eligible to join the CMS Network plan to determine which members in the data in any time period would fall into this category.

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22	Are the risk scores the same ones that are reflected in historical/current TANF & SSI Medicaid only payment rates? Or did you rescore based on new weights? Which models were used for the historical non-scored members (CMSN recipients, as well as capitated plan SSI Dual eligible, HIV/Aids, LTC, Child welfare recipients)	The risk scores in the MMA data book are the same risk scores determined as part of the quarterly risk adjustment process for Florida's MMA program during the SFY 14/15 and SFY 15/16 historical periods. Please refer to the "Risk Score Assignment" portion of Section II of the MMA data book narrative for more complete information regarding the risk scores included in the data book.
23	Can you provide prevalence distributions by rate cell under the risk score models?	This information is not readily available.
24	Where can we find the weights and diagnoses mappings of the risk models used in the data book?	Please refer to the attached reports titled "Chang29 - RY 14-15 MMA Risk Weight Updates.pdf", "Report16 - MMA Risk Weights for Sept 2015 - Feb 2016.pdf" and "Report04 - MMA Risk Weights for March 2016 - Aug 2016.pdf". Please note that each report corresponds with a rate year whereas the data book is summarized by state fiscal year and therefore contains risk scores from two rate years.
25	Can you confirm that the risk scores contain information for excluded members, when the exposure and claims for those members have been removed?	The MMA data book includes prospective risk scores for all cohorts of members who had at least six months of Medicaid eligibility in the risk score study period, including MMA populations to which risk adjustment has not applied to date. Please refer to the "Risk Score Assignment" portion of Section II of the MMA data book narrative for more complete information regarding the risk scores included in the data book.
26	Did you use the sub-capitated encounter data for the development of the risk scores?	Yes. All relevant FFS and encounter data in FMMIS is used for risk adjustment.
27	For the 3 plans no longer participating in the MMA where the encounter data and ASR data wasn't included, is there any reason to believe that the data from the removed plan had higher costs? What were the member months and the associated costs for the capitated plans no longer participating and what was their duration of being in the program?	Acuity adjustments for missing data will be included in the cost proposal instructions / rate methodology report provided with the ITN. Please see column G ("MMA Plan-Specific Exclusion") in the 'Eligibility Data' tab of Appendix M-1 for information on the member months with missing data.
28	Can you provide the amount of non-Medicaid covered pharmacy drugs removed for the HIV/Aids dual eligible membership? Please explain why these claims were included in the encounter data? Are other dual eligible non-Medicaid covered claims excluded?	Some Medicaid recipients receive services as Medicaid-only members but later are retroactively identified as dual eligible members. As a result, their claims may have been initially paid assuming Medicaid was the primary payer. AHCA's FFS data and eligibility data generally reflect restatements to reduce the claim amounts to appropriate levels given that Medicaid is the secondary payer. However, capitated plan encounter and financial data submissions do not always accurately reflect retroactive restatements for dual eligible members. For the HIV / AIDS Dual Eligible category, we explicitly removed any non-Medicaid-covered pharmacy costs from the data so that high cost HIV / AIDS drugs are excluded from the data. The cost proposal instructions / rate methodology report provided with the ITN will provide information regarding third party liability adjustments for other dual eligible rate groups.
29	Please provide summaries of the amounts excluded due to being in the expanded benefits category.	The final data book will include a summary of expanded benefits.
30	Please provide the algorithm used to remove transplant costs. Will the transplant kick payment be paid in addition to the normal category of aid monthly payment? Please confirm you have not adjusted the exposure for the transplant time period.	The current transplant kick payment covers heart, liver and lung transplants. The guidelines are on the Agency's website. All member months for members receiving transplant services are included in the data book. Transplant costs were removed based on plan-reported values in the transplant service categories of the encounter data and ASR financial data.
31	On the FFS express Medicaid enrollment, how are partial member months counted?	For members enrolled in MMA plans for a partial month after the Express Enrollment effective date, partial member months are counted based on a field in the Agency's eligibility file that indicates the fraction of a month for which a member is enrolled in an MMA plan. For members in the FFS Express Enrollment delivery system in the MMA data book, partial month information is not available; therefore, the identification algorithm used to identify members who were enrolled in the Agency's FFS program during the historical data period that would now be enrolled in MMA under the Express Enrollment initiative considers only full months of claims and membership.

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32	There is a reference to APR-DRG and EAPG assignment. Where can we learn more about the timing around the reimbursement change?	The Agency implemented an APR-DRG payment system for qualifying FFS inpatient admissions starting on July 1, 2013. The Agency will implement an EAPG payment system for qualifying FFS outpatient and ambulatory surgery center claims starting July 1, 2017. The APR-DRG and EAPG FFS payment rates are updated annually effective on July 1.
33	In the AHCA FFS data, you indicated that the pharmacy claims for HIV/Aids patients was limited to only those covered by Medicaid. Please explain what drugs were included in the AHCA FFS data that weren't covered by Medicaid and why they were paid.	Some Medicaid recipients receive services as Medicaid-only members but later are retroactively identified as dual eligible members. As a result, their claims may have been initially paid assuming Medicaid was the primary payer. AHCA's FFS data and eligibility data generally reflect restatements to reduce the claim amounts to appropriate levels given that Medicaid is the secondary payer. The data book excludes any non-Medicaid pharmacy claims for HIV/AIDS Dual Eligible members that remained in the FFS data.
34	Please explain the medical school faculty physician group pass-through payment PMPM	In the RY 16/17 and 17/18 capitation rate period, capitated plans were required to pay medical school faculty physician groups to supplement current payments made to the physician groups.
35	Please explain the behavioral health reform wavier services and indicate what the monthly payment for the members who use these services.	Please see the Agency's June 2016 request to amend Florida's 1115 Managed Medical Assistance Waiver at http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth_amend_waiver_2016-06.shtml. The Agency is in the process of seeking federal approval to pay for services for persons with severe mental illness or substance use disorders. Payments will be made as enhanced capitation rates, but payment amounts have not been finalized at this time and are contingent upon the package of services approved by the Centers for Medicare & Medicaid Services.
36	Please quantify the amount of claims excluded for recipient IDs that do not match to a member month in AHCA's eligibility file.	The final data book narrative will include this information.
37	Please quantify the amount of claims excluded for members who are not mapped to a valid MMA rate group or rate cell.	The final data book narrative will include this information.
38	Will you provide summary exhibits, similar to the Appendix M-2 exhibits, to help us reconcile the detail for the CMSN population?	Exhibits M-1U, M-1V, M-2U, M-2V, M-3U, M-3V, M-5U, M-5V, M-6, and M-9 include summary information for the CMSN population in Appendix M-2.
39	Will the CMSN population continue to be a voluntary managed care population?	The Agency can not respond at this time.
40	Does the current MMA program allow for plans to collect cost-sharing for any services? If so, how is it handled in the data?	Capitated plans are allowed to impose member copays on certain services in the current MMA program according to FFS program rules. The data book reflects plan paid amounts net of any copays. Any copays waived by plans are reported as expanded benefits.
41	Will the following categories remain voluntary starting in 2018? Program for the All-Inclusive for the Elderly (PACE) plan members Familial Dysautonomia waiver Model waiver (age 18-20) (Not identified by aid category) – recipients with other creditable coverage (TPL) EXCLUDING MEDICARE Recipients on the Developmentally Disabled (DD) HCBS waiting list	The Agency will continue to comply with statutory requirements for voluntary populations as specified in Part IV of Chapter 409, Florida Statutes.
42	Can you provide a summary of the expanded benefit costs from the ASRs?	The final data book will include a summary of expanded benefits.
43	Are there any known/consistent differences worth noting between AHCA eligibility vs the member months reported on the ASR.	As part of the final data book, an adjustment has been made for one MCO in Region 11 where a notable difference in membership was noted. Please refer to the data book narrative for additional details of this adjustment.
44	Please provide the costs and exposure of the historical programs: • Project AIDS Care • Traumatic Brain and Spinal Cord Injury • Adult Cystic Fibrosis • Express Enrollment	Please refer to the answer to question #13.
45	Does the current program allow for plans to collect cost-sharing for any services? If so, how is it handled in the data?	There is no cost sharing for LTSS beyond member patient responsibility is collected.
46	Can you confirm that the difference between the Special Feed LTC Encounter Data Experience and the ASR Report Financial Experience is entirely due to completion? If not, how do they reconcile?	The data book illustrates that, overall, encounter data reporting is somewhat incomplete relative to ASR reporting. Consideration of encounter data completeness in bidding and rate development will be addressed as part of the cost proposal instructions / rate methodology report provided with the ITN.

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EXHIBIT C-8
STATEWIDE MEDICAID MANAGED CARE DATA BOOK QUESTIONS AND ANSWERS

#	Question/Comment	Response
47	The RY 16/17 rate certification base data had a missing data acuity adjustment. What changed in the data collection process so that a similar adjustment is not required for the data book?	Consideration of encounter data completeness in bidding and rate development will be addressed as part of the cost proposal instructions / rate methodology report provided with the ITN.
48	What is the basis for the MMA cost per service for the Encounter Data in exhibit M-1A and the FFS claims in exhibit M-4A? Are the claims and encounters priced/repriced at the then current Florida Medicaid fee schedule?	The MMA data book reflects paid claims. Claims are not repriced to FFS reimbursement rates.
49	What is the current status of MMA and LTC member eligibility redetermination?	This question is unclear and cannot be answered. You can find current Medicaid managed care enrollment report on the Agency's web page at http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml.
50	How has the level of activity varied during the experience period?	It is unclear what "level of activity" means in the question.
51	What are the plans for the level of activity in the future compared to the current level?	The Agency can not respond at this time.
52	Are there reports available that show the number of redeterminations by month and the outcomes of those redeterminations?	This question is unclear and cannot be answered.
53	Are capitated plans required to use the Florida preferred drug list for their formulary? Was this required in the time period covered by the base data?	Yes.
54	Is the current and historical PDL available on line?	Yes.
55	Does special drug category include both brand and generic specialty drugs?	The service categories for specialty drugs (category M8.d in the encounter data, bucket 14d in the FFS data) include both brand specialty drugs and generic specialty drugs
56	Will there be an open enrollment for all MMA members 1/1/2019	The Agency can not respond at this time.
57	Will there be an open enrollment for all LTC members 1/1/2019	The Agency can not respond at this time.
58	How are retroactive enrollments handled under the program and in the data book?	Retroactive eligibility periods are excluded from the data book.
59	What transplants are carved out for 2019? What services pre- and post-transplant does this carve out include?	The Agency can not respond at this time.
60	What prescription drugs are not covered by MMA?	Florida Medicaid does not reimburse for drugs that have no federal rebates or for drugs that are classified as ineffective by DESI**.
61	Are historical ASRs available for review?	The historical ASRs are not published.
62	When will the 2016 ASRs be available for review?	The historical ASRs are not published.
63	Please identify the risk model used to develop the risk spores for each experience period. Please identify the time periods during the experience period when the same risk weights were used for a given population. We are seeking to understand if the risk scores are comparable over time for the same member category.	Please refer to the answers to questions #22 and #24. Please refer to the "Risk Score Assignment" portion of Section II of the MMA data book narrative for more complete information regarding the risk scores included in the data book.
64	Please provide more detail on the rate setting process.	The Agency can not respond at this time.
65	Will the ITN describe the rate setting process in detail?	The Agency can not respond at this time.
66	Will the ITN describe the rate renewal process in detail?	The Agency can not respond at this time.
67	Will the state set the 2019 rates as a blend of the rates bid by the MCOs?	The Agency can not respond at this time.
68	What time period is covered by the ITN?	The Agency can not respond at this time.
69	Page 17 of the MMA data book refers to 'the January 2019 – September 2019 rate year…" Please describe the purpose of this partial year.	The Agency can not respond at this time.
70	Will there be a maternity kick payment in 2019 as in the current program?	The Agency can not respond at this time.
71	Can guidance be provided regarding the detail desired in the pro forma financial statements? For example should investments be itemized? Accounts receivable, etc.? Should revenue or claims be segregated by area, type (TANF, SSI, etc.)?	The Agency can not respond at this time.
72	Please quantify the amount of claims excluded for recipient IDs that do not match to a member month in AHCA's eligibility file.	Please refer to the answer to question #36.
73	Please quantify the amount of claims excluded for members who are not mapped to a valid MMA rate group or rate cell.	Please refer to the answer to question #37.
74	Will you provide summary exhibits, similar to the Appendix M-2 exhibits, to help us reconcile the detail for the CMSN population?	Please refer to the answer to question #38.
75	Is there any chance that CMSN will be a separate rate cell going forward?	The Agency can not respond at this time.
76	Will the CMSN population continue to be a voluntary managed care population?	The Agency can not respond at this time.
77	For the 3 plans no longer participating in the MMA where the encounter data and ASR data wasn't included, is there any reason to believe that the data from the removed plan had higher costs? What were the member months and the associated costs for the capitated plans no longer participating and what was their duration of being in the program?	Please refer to the answer to question #27.
78	Please provide summaries of the amounts excluded due to being in the expanded benefits category.	The final data book will include a summary of expanded benefits.
79	Will varying weights be applied to each year of the data when developing a rate range? If so, please confirm the weights applied to each year.	The Agency can not respond at this time.
80	To identify SMI individuals in the data book, did the SMI assignment algorithm review all available diagnosis codes for each individual?	The SMI algorithm uses the first four diagnosis codes to align with the Agency's algorithm for rate cell assignment and capitation rate payment.
81	Will varying weights be applied to each year of the data when developing a rate range? If so, please confirm the weights applied to each year.	The Agency can not respond at this time.

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82	"The LTC data book also excludes experience for the three new waiver populations that may become mandatory participants in the LTC program beginning January 1, 2018…If mandatory enrollment for these populations is legislatively approved, an appropriate adjustment to capitation rates will be made." What adjustments would be made to account for the new waiver populations?	Please refer to the answer to question #13.
83	"Year 4 rate cell assignments were not finalized prior to the submission of CY2016 ASR reports. As such, the final month Year 3 ASR data was reported using the Year 3 rate cell assignment." Will Milliman release updated Year 3 ASR data using the Year 4 rate cell assignment? If so, when will the update be available?	It is not possible to restate ASR financial data retrospectively with Year 4 flags for September 2016. We do not believe this has a material impact on rate development.
84	"A program change to include express enrollment for the LTC population will be part of the ITN." Is there information available regarding the LTC express enrollment process, eligibility for express enrollment, and expectations on its impact to claims costs? If not, when will this information become available?	The Agency can not respond at this time.
85	For the common service categories in exhibits L-C and L-D, how will Milliman use the claims data from ASR report and/or that from encounter data to develop a rate range? Will claims costs in ASR report data be blended with encounter data?	The Agency can not respond at this time.
86	Why is there not a penalty for the managed care provider not following the guidelines?	This question is unrelated to the data book.
87	Why is AHCA not addressing our complaints and following up with the managed care providers? We are required to continually check with the managed care and keep AHCA updated.	This question is unrelated to the data book.
88	Per the Medicaid Handbook Medicare Emergency crossovers are to be paid at 100%. When the managed care provider renders payment, they are stating they are not responsible for mileage (A0425). When we take this to AHCA, they send it to Policy for review instead of forcing the managed care to follow the ruling already stated in the Medicaid Handbook. Why would sent to Policy when it is already established?	This question is unrelated to the data book.
89	Why does are the managed care providers not held accountable for knowinf the regulations, like providers are?	This question is unrelated to the data book.
90	What are the remaining drivers of variance between the ASR and Special Feed Encounter data please? How should this variance influence the way in which bidders use the information?	Please refer to the answer to question #46.
91	Can you please provide the impact of historical and prospective nursing facility fee schedule changes by region?	This is on AHCA's website.
92	Can you please provide the impact of the following changes, by region? a. Historical and prospective fee schedule changes b. Historical and prospective program changes, including the addition of pediatric specialists (cardiologists, endocrinologists, nephrologists, neurologists, and psychiatrists) to the Physician Incentive Program effective 10/1/17	Historical fee schedules can be accessed on AHCA's website (http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml). The cost proposal instructions / rate methodology report provided with the ITN will address the treatment of historical and prospective program changes.
93	On the LTSS databook slides presented on 4/12, slide 19, please confirm that the statewide impact on enrollment and utilization that the reassignment of member months results in a 4.0% net decrease in non-HCBS member months and 4.1% net increase in the HCBS member months.	The rate cells listed on the slides were switched. As part of the projected rate cell development, 7.4% of non-HCBS member months were moved to the HCBS rate cell, and 3.5% of the HCBS member months were moved to the non-HCBS rate cell. This resulted in a net decrease of 4.1% for non-HCBS and a net increase of 4.0% for HCBS. Due to update of Year 4 flags in the final data book from preliminary to final flags, these values have slightly changed to 7.3% of non-HCBS member months moved to the HCBS rate cell and 3.5% of the HCBS member months were moved to the non-HCBS rate cell.
94	At the databook meeting, it was indicated that the reassignment of enrollment and costs resulted in members moving both ways (some previously categorized as HCBS moving to non-HCBS and some previously categorized as non-HCBS moving to HCBS). From the databook, we know that the net amount of movement is 22,287 increase in HCBS members. Can you please provide the gross movements of the membership? That is, a. how many member months moved from HCBS to non-HCBS? b. how many member months moved from non-HCBS to HCBS? For each of the member month cohorts in a and b above, can you please indicate the historical PMPM costs of each cohort that was moved? Please provide the PMPM costs for each cohort based on each of the ASR and encounter data sources	Please refer to the answer to question #93.
95	Please explain how you moved costs between HCBS and non-HCBS using the ASR data (Exhibit L-A3 vs Exhibit L-C3)? Is the ASR data by member or was some estimate of costs used?	The percentage changes in costs calculated in the encounter data were applied to the corresponding categories of service in the ASR data. For ASR categories not reflected in the encounter data, the overall percentage change in the encounter data across all categories of service was applied other than for case management where no adjustment was made.

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96	When comparing total costs in Exhibit L-D3 to Exhibit L-B3, the amounts are exactly the same. When comparing the total costs in Exhibit L-C3 to Exhibit L-A3, the amounts are off slightly (See in cell comment). Can you explain what is causing this small discrepancy?	The total cost difference between the two exhibits was 0.00004%. This difference will be eliminated in the revised data book exhibits.
97	At the databook meeting, you indicated more detail regarding the risk scores in the databook regarding the monthly and/or quarterly risk scores that were summarized in the databook relative to what plans were provided on a quarterly basis. Can you please document the similarities/differences in writing for us?	Please refer to the answers to questions #22 and #24. Please refer to the "Risk Score Assignment" portion of Section II of the MMA data book narrative for more complete information regarding the risk scores included in the data book.
98	Has anyone addressed the Medicare Crossover claims and how they are all directed to Medicaid? This is causing Medicaid to pay on claims that are covered by Logisticare and we are having to refund the overpayment.	This question is unrelated to the data book.
99	We respectfully request that the state provide an addendum to the data book identifying the basis for contractual payments (relative % of Medicaid FFS) so that each MCO can evaluate their contracts relative to the data book and make the appropriate adjustments in our analysis. We believe a % of Medicaid for each rate cell / COS / Region would be reasonable.	The final data book will include a summary of historical provider contracting levels for SFY 15/16.
100	Inaccurate Encounter Data – The Encounter Data available to the Agency is collected from Claims Data. Codes and their payment rates, units, etcetera, are made available to the Agency which compiles the information. Unfortunately many claims have not been paid. For dozens of reasons, claims going back to early 2016, if not farther, have not been paid to many providers because of improper use of the Florida Medicaid DME fee and code schedule, problematic health plan software configuration issues, authorization inaccuracy, etc. As a result many claims have not been finalized and the data has not been sent to the Agency. This reason alone makes all the data suspect.	Not a question.
101	Codes are Inaccurate – Initially after the fall of Univita, because of urgency, and ongoing for over a year because of the improper training and or supervision, Managed Care Organization authorization departments utilized incorrect codes. Services were rendered but the actual codes needed were not used and therefore not properly recorded in the system. After claims projects, many of the services were paid, but again, not recorded properly. There is concern that many standard services and most outliers were improperly recorded.	Not a question.
102	Settlements – Our Company, like many others, appreciates settlements with Managed Care Organizations because it means we are to be paid, but normally settlements are the result of extended failures to come to a final agreement for monies owed and services rendered. By their very existence settlements prove that not all data could be accurately collected, codes were not accurate, units may be incorrect, if services were agreed to. As a result the agency is not getting accurate data and that information may not be properly recorded if at all, contributing to inaccurate data.	Not a question.
103	Miscellaneous Codes – There has been an abundance of miscellaneous codes used by many Managed Care Organization. In some cases up to 20% of all orders for some MCOs have been ordered utilizing miscellaneous codes. These codes were used as 'catch alls', especially after the transition from Univita while newly hired professionals were not properly or fully trained to correctly order services. Thus the encounter data is fully of inaccuracies in 2016. Certain areas are not properly defined in codes and some are missing entirely.	Not a question.
104	Payments – Because of the issues listed in other comments, millions of dollars in claims have yet to be paid. This means that the data book information is incomplete, and the numbers reflected are much lower than they should be.	Not a question.
105	Univita Legacy - Univita was one of the largest Medicaid failures in Florida history, the ancillary provider managed nearly 90% of the ancillary service of Medicaid members in the state before its bankruptcy. Univita did not keep regularly provider encounter data nor send it to the Managed Care Organizations they served. The data provided was not only accurate considering that Univita closed in the Summer of 2015, Data from before its closure cannot be considered accurate for Home Health, infusion and DME services. Additionally, the failure of Univita left Managed Care Organization scrambling to replace the providers of service, authorizing verbally, crafting new authorizations with untrained staff, and not having the necessary knowledge in middle and upper management to assure compliance with guideline and regulations over and above data and claims. It was not until 2016 that most Managed Care organizations bettered their services, yet still, the problems persisted throughout the balance of 2016 as MCOs hired, re-trained, reevaluated Univita rendered services and tried to fully consider the debts Univita left behind, that the MCOS were forced to pay. Again the result of that debacle is an inability to trust the encounter data and points. It is believed that 40 percent of claims were wrong, and we can document that even today many health plans have yet to pay providers monies owed from early 2016 and beyond. The data is suspect.	Not a question.
106	Fee Schedule - Lastly, the very nature of the Medicaid Code and Fee schedule for DME is not accurate for modern usage. The Schedule is 20 years old with a minor update being prepared for release in 2017. The code schedule has had to be worked around and it is also the reason for the plethora of miscellaneous codes. Miscellaneous codes of for equipment and supplies are used for such a wide variety of products and prices that is has been completely impossible to categorize the items used. A large portion of the DME usage in Florida Medicaid is not properly accounted for in the encounter data.	Not a question.
107	Medicare Coding – One plan has made the decision to authorize work using Medicare and national HCSPCS codes not Medicaid, which has differing unit requirements, costs and codes descriptions. Because, the Medicare fee schedule does not compare with the Medicaid fee schedule claims are missing. Merging the schedules is not fully possible, again raising questions about the data book.	Not a question.

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#	Question/Comment	Response
108	Lastly, as rates are being set for the first of 5 year contracts it is necessary to consider the need to expand home based services in Medicaid in an effort to lessen the financial burden of the State. Home based care is 1/3rd and more the cost of nursing home care. Investments in Medical Equipment and technology in managed care is at the behest of the Managed Care Organization as they see fit, but if the monies available are too constrained the provider community will not even be able to offer such advances, investment, which will pay off largely in the long run. We believe there needs to be a bump in considered monies available to assist in expanding at home services to reduce costs.	Not a question.
109	Although there is mention of new services that will be covered, was there any adjustment for services that are expected to be reduced in future years either because of changes in coverage or changes in practice patterns (e.g., availability of generic drugs)? If not, what recommendations would you give respondents in recognizing these potential changes in liability with the data at its current level of granularity?	The cost proposal instructions / rate methodology report provided with the ITN will address the treatment of historical and prospective program changes.
110	On page 13 of the data book Narrative, the State's actuary discusses the influence of the serious mental illness population on the risk model. In 2014 / 2015, it reads as though the model has a separate coefficient for SMI. In 2015 / 2016, there are separate models depending on the identification of a person with SMI. If we have understood the approach correctly, please clarify the reason for the change and how the change might inhibit comparisons between the populations from one period to the next? In addition, will AHCA be releasing any information about the changes in risk score over time (both past and projected on the same risk score model) so that respondents might more clearly understand how the population's aggregate morbidity is changing over time?	Please refer to the answers to questions #22 and #24. Please refer to the "Risk Score Assignment" portion of Section II of the MMA data book narrative for more complete information regarding the risk scores included in the data book. No additional risk score information will be released.
111	On page 16 of the data book Narrative, the State's actuary mentions that they removed claims for capitated plans no longer participating in the MMA. Can you share when these plans left, what regions they covered, and how large their covered population was? Might the beneficiaries in question still be present in the data under a subsequent capitated plan?	The following plans left the MMA program during the historical data period: First Coast Advantage as of 12/1/2014 (Region 4), Preferred Medical Plan as of 8/1/2015 (Region 11), and Integral Quality Care as of 11/1/2015 (Regions 1, 6, and 8). Please see column G ("MMA Plan-Specific Exclusion") in the 'Eligibility Data' tab of Appendix M-1 for information on the member months with missing data. Yes, members that were enrolled in the capitated plans no longer participating in MMA are enrolled in other capitated plans if the member is still eligible to participate in the Medicaid program.
112	Similarly, page 16 of the data book Narrative specifies that the State's actuary removed claims for beneficiaries without a corresponding eligibility record. What percentage of the claims were removed? There is an inferred exposure with each beneficiary whose costs were removed. How did the costs for these removed individuals compare against others in the same rate cells?	Please refer to the answer to question #36. Also, please note that since these claims are for member IDs that do not exist for the given month in AHCA's eligibility file, the claims are not for valid MMA members, and it is not possible to determine the impact by rate cell.
113	Page 26 of the data book Narrative indicates that adjustments for "data smoothing for rate groups with non-credible data" were not incorporated into the data book. From the Narrative, it does not appear as though the claims in the data book are truncated. If the data are not truncated, what recommendations might the State give for assessing whether or not a cell is skewed by the presence of one or more high cost claimants?	Historically, the HIV/AIDS Dual Eligible rate group is the only rate group where a smoothing adjustment has been applied in the MMA rate development process.

* Please note that questions/comments have not been reworded.