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Justification Review

May 2001 **Report No. 01-27**

Medicaid Disease Management Initiative Sluggish, Cost Savings Not Determined, Design Changes Needed

at a glance

The 1997 Florida Legislature directed the Agency for Health Care Administration to implement a disease management initiative to improve health outcomes and reduce taxpayer costs for Medicaid clients with asthma, diabetes, HIV/AIDS, and hemophilia. Legislation passed in 1998 expanded the initiative to include Medicaid clients with hypertension, cancer, end-stage renal disease, congestive heart failure, and sickle cell anemia.

The still incomplete initiative cost the state $24.1 million through February 2001. The agency has not determined whether the initiative improved health outcomes and saved the $112.7 million projected over four years. In February 2001, the agency backed off making a vendor repay $7.6 million because the agency did not establish an explicit method to measure cost savings before contracting for disease management services.

In general, the agency failed to address significant problems that impeded the initiative. Further, the initiative design does not adequately address problems of the chronically ill who often suffer from multiple diseases. In addition, the design is inefficient and fosters inconsistencies.

We recommend that the Legislature direct the agency to

- redesign the initiative from a disease-specific to a patient-focused or holistic approach and contract with fewer companies;
- establish a defensible methodology to determine cost savings and ensure that overpayments are recovered;
- report on initiative progress in meeting performance expectations, including health outcomes and cost savings; and
- require OPPAGA to complete a second review of the initiative by December 31, 2002, that reports on whether legislative expectations regarding cost savings and program outcomes are met.

Purpose

Section 11.513, *Florida Statutes,* directs the Office of Program Policy Analysis and Government Accountability to complete a program evaluation and justification review for each state agency that is operating under a performance-based program budget. Justification reviews assess agency performance measures and standards, evaluate program performance, and identify policy alternatives for improving services and reducing costs.

This report is one of four that reviews the Medicaid program administered by the Agency for Health Care Administration. In the other three reports, we address program accountability and performance; effectiveness of fraud and abuse activities; and cost control policies for Medicaid's prescription drug program. This report

- assesses how successful the disease management initiative has been in meeting legislative expectations for anticipated cost savings and other program outcomes;
- identifies circumstances or factors impeding initiative success; and
- recommends ways to improve the design of the initiative.

Office of Program Policy Analysis and Government Accountability
an office of the Florida Legislature

Background

In an effort to help control expenditures for chronically ill Medicaid clients, the Florida Legislature in 1997 directed the Agency for Health Care Administration to implement a disease management initiative for Medicaid clients diagnosed with asthma, diabetes, HIV/AIDS, and hemophilia. The Legislature reduced Medicaid appropriations based on anticipated savings that were to be achieved through this initiative.

In Fiscal Years 1998-99 and 2000-01, the Legislature directed the agency to expand the initiative and develop programs for hypertension, cancer, congestive heart failure, end-stage renal disease, and sickle cell anemia. The Legislature made further Medicaid budget reductions based on the additional expected savings.[1] The Legislature anticipated cost savings over four years to total $112.7 million. (See Exhibit 1.)

Exhibit 1
The Medicaid Disease Management Initiative Was Expected to Save $112.7 Million Over Four Years

Fiscal Year	Anticipated Savings (millions)	Disease Management Initiative
1997-98	$ 4.2	Implement disease management for asthma, diabetes, HIV/AIDS, and hemophilia.
1998-99	24.7	Continue disease management for the initial four diseases.
1998-99	14.7	Expand disease management to include cancer, end-stage renal disease, congestive heart failure, hypertension, and sickle cell anemia.
1999-00	0.0	No additional disease management reductions or expansions.
2000-01	23.0	Improve disease management efficiency for the nine diseases.
2000-01	46.1	Expand disease management to include population-based disease management and diseases not already covered by the initiative.
Total	**$112.7**	

Source: General Appropriations Acts of 1997-98, 1998-99, and 2000-01.

Disease management seeks to improve patient care and health outcomes and to reduce health care costs by concentrating services on chronically ill patients who often receive fragmented care, do not follow treatment and medication regimens, experience a high rate of preventable complications, and have high use of costly services. Disease management offers an integrated approach to treating chronic disease by providing support to patients and physicians. For example, by using a care manager, disease management helps patients follow appropriate treatments, use less expensive outpatient interventions, and learn how to self-monitor their conditions. Disease management encourages doctors to use best practice guidelines for optimal treatment and enhances communication between patients and caregivers to prevent duplication or gaps in treatment.

Florida's disease management initiative delivers services to Medicaid clients enrolled in MediPass using disease management organizations (DMOs), which are private companies that specialize in disease management.[2] These companies provide a range of services to both MediPass clients and providers. DMOs concentrate these services through a care manager who coordinates all aspects of patient care by developing individual care plans, monitoring patient compliance of treatment protocols, and informing physicians of patient progress. DMOs also provide services and educational materials to physicians by sharing best practice guidelines and offering to conduct educational conferences. In addition, DMOs sometimes engage in community outreach by participating in or sponsoring health fairs. (See Appendix A.)

A disease management program for MediPass clients with asthma began in August 1998. Integrated Therapeutics Group, the DMO providing services to asthma clients, did so free of charge through a formal agreement. Disease management services for diabetes, hemophilia, and HIV/AIDS were all operating by September 1999 and are delivered through

[1] This was done through proviso language in the 1997-98, 1998-99, and 2000-01 General Appropriations Acts.

[2] MediPass is Florida's primary care case management program for Medicaid clients.

fee-based contracts with four DMOs.[3] Disease management programs for end-stage renal disease and congestive heart failure began in the fall of 2000. The agency plans to contract with DMOs to provide disease management programs for hypertension and sickle cell anemia within the next few months.[4]

The agency expects that Medicaid costs for clients with chronic diseases will decrease because of the services provided by DMOs. Except for Integrated Therapeutics Group, the agency advances a monthly fee to the DMOs based on the number of clients the agency identifies as eligible for a respective program.[5] This payment serves as an advance against anticipated cost savings. As of March 2001, the agency had advanced $24.1 million to the DMOs. (See Exhibit 2 for totals by disease management program, and Appendix B, Table B-2 for advanced payments to individual DMOs.)

Exhibit 2
Through February 2001, the Agency Has Advanced $24.1 Million to Deliver Disease Management Programs

Disease Management Program	Advanced Payments (M = million) For FY 1999-00	To Date for FY 2000-01	Total Through February 2001
Diabetes	$8.2 M[1]	$5.4 M	$13.6 M
HIV/AIDS	$2.0 M	$3.1 M	$5.1 M
Hemophilia	$74,000	$54,900	$128,900
End-Stage Renal Disease [2]		$3.4 M	$3.4 M
Congestive Heart Failure [2]		$1.9 M	$1.9 M
Totals	**$10.3 M**	**$13.8 M**	**$24.1 M**

[1] This total includes the month of June from Fiscal Year 1998-99.

[2] These disease management programs started in September 2000, and thus have operated for less than a full year.

Source: Agency for Health Care Administration.

[3] The agency split the state between two DMOs for hemophilia. The diabetes program began operations in May 1999, the HIV/AIDS program in August 1999, and the hemophilia program in September 1999.

[4] The agency does not currently plan to bid for a cancer disease management program; however, the agency plans to include leukemia in its bid for a DMO to provide disease management for hematology.

[5] The monthly payment is based on a per-member, per-month fee that varies by disease management organization.

At the end of each contract year, the agency is to determine whether the DMO has realized cost savings. To accomplish this, the agency will compare Medicaid expenditures incurred during that year for clients eligible for DMO services to expenditures for eligible clients incurred during a baseline period.[6] If the contract year expenses for eligible clients exceed baseline expenses, the DMO must refund the total amount of the advanced monthly fees. If contract year expenses are less than those incurred during the baseline period, the DMO will receive a negotiated percentage of the savings.[7]

The contracts for end-stage renal disease and congestive heart failure disease management stipulate that client expenses during a contract year must be 6.5% less than expenses during the baseline period. The agency plans to include this 6.5% guaranteed savings in all future contracts.

Findings

Initiative Implementation and Assessment Slow

The agency has not completely implemented the initiative even though directed to do so by the Legislature more than three years ago

The Legislature directed the agency to implement the disease management initiative for clients with specific diseases in 1997 and 1998. However, as of March 2001, programs exist for only five of the nine disease states indicated by the Legislature, and two of the programs do not cover the entire state. (See Appendix B.)

[6] Baseline expenditures refer to expected Medicaid costs in the absence of implementing disease management, adjusted for inflation, during a specific time frame referred to as the baseline period. The fiscal year prior to the program generally serves as the baseline period.

[7] The percentage that the DMOs receive varies by DMO depending on contract negotiations.

At this time, the initiative does not include disease management programs for sickle cell anemia, hypertension, cancer, or asthma. While the agency is currently planning to bid for sickle cell anemia and hypertension disease management programs, it is not currently pursuing a cancer program. Agency staff told us they have not decided whether to target a specific cancer initially and phase in other types of cancer or implement disease management for all types of cancer.

The initiative also no longer offers disease management for MediPass clients with asthma. Integrated Therapeutics Group discontinued services in January 2001 after backing out of negotiations with the agency to formalize a contract. Negotiations broke down because the DMO did not agree to the guaranteed savings required by the agency in exchange for a formulary comprising drugs manufactured by the pharmaceutical company that owns Integrated Therapeutic Group.

The initiative does not provide services statewide for MediPass clients with HIV/AIDS or congestive heart failure. Although available in the rest of the state since September 1999, HIV/AIDS disease management is not available for MediPass clients in Broward and Dade counties, where an average of 3,000 MediPass recipients qualify for HIV/AIDS disease management services. While the agency selected a DMO to provide HIV/AIDS disease management in these counties over a year ago, the agency and DMO have not yet reached agreement on contract terms. Further, while nothing precludes the agency from doing so, it has not sought another company to deliver disease management services to MediPass clients with HIV/AIDS in these two counties.

The congestive heart failure program covers clients in only 52 of Florida's 67 counties. Although the agency originally planned to contract the remaining 15 counties with Coordinated Care Solutions, the DMO that delivers diabetes disease management services, Coordinated Care Solutions backed out of negotiations. The agency currently plans to pursue a contract for congestive heart failure disease management in these 15 counties.

In addition to failing to implement the initiative as directed by the Legislature, the existing disease management programs only serve a small percentage of eligible clients. As further discussed on page 6, these programs are serving only between 6% and 58% of the target populations. Thus, the agency has not implemented the disease management program as mandated by the Legislature, and Medicaid clients with the specified chronic health conditions have not received the benefits of the program.

The agency has not determined whether the initiative has achieved the cost savings anticipated by the Legislature or improved the health outcomes of Medicaid clients with chronic diseases

The Legislature directed the agency to implement the disease management initiative in order to decrease costs and improve health outcomes associated with providing health care services to MediPass clients with chronic diseases. In addition, one of the main principles of disease management is measuring outcomes to determine program effectiveness. However, the agency has neither completed cost analyses nor assessed program performance, even though DMOs have delivered services to Medicaid clients diagnosed with asthma since August 1998 and with diabetes, hemophilia, or HIV/AIDS since the summer and fall of 1999. (See Exhibit 3.)

Exhibit 3
DMOs Began Delivering Disease Management Programs in 1998 and 1999

Disease State	Date of First Service Year
Asthma	August 1998 - July 1999
Diabetes	May1999 - April 2000
HIV/AIDS	August 1999 - July 2000
Hemophilia	September 1999 - August 2000

Source: Agency for Health Care Administration.

Although the Legislature anticipated that the disease management initiative would save $43.6 million by the end of the second year, as of March 2001, the agency has not completed analyses to determine whether the initiative has saved money. Because of slow implementation, it is highly unlikely that the initiative has saved the $43.6 million that the Legislature expected it to save after two years. In addition, it is unlikely that the disease management enhancements recommended by the Legislature will yield the $69.1 million in savings expected for the 2000-01 fiscal year. This failure to achieve the total expected savings of $112.7 million has likely contributed to the $1.5 billion deficit projected in the Medicaid program for Fiscal Year 2001-02.

The agency did not establish and include in the DMO contracts an explicit methodology for determining cost savings prior to implementing the disease management initiative. This makes the agency vulnerable to disputes over whether or not savings are achieved. An agency analysis conducted in January 2001 indicated that total Medicaid costs for clients in the diabetes disease management program exceeded baseline costs by $5.3 million, and that Coordinated Care Solutions should refund to the agency the $7.6 million it received in advance fees. However, after Coordinated Care Solutions disputed the agency's analysis, the agency rescinded its request for repayment of the advanced fees until the agency and Coordinated Care Solutions agree on the methodology used to assess cost savings. The agency should take steps to resolve this conflict as soon as possible and recover any fees that Coordinated Care Solutions should refund to the agency.

Staff also indicated that claims processing lag times and staff turnover contributed to delays in completing analyses. The agency has experienced turnover of staff dedicated to working with the disease management initiative and only recently has put together a team focused on the disease management initiative. [8]

Even considering claims processing lag times, the agency has had adequate time to finalize methodology issues and complete cost-savings analyses. This is especially true for the asthma disease management program that operated from August 1998 through January 2001 and the diabetes disease management program that has operated since May 1999. At a minimum, the agency could have completed cost-savings analyses for these two programs by the end of 2000. Even so, as of March 2001, the agency still has not determined cost savings, although the initiative has been operating for over two and one-half years.

After two years, the agency also does not know whether disease management has improved the health outcomes of Medicaid clients with chronic diseases. In addition to saving money, disease management is expected to improve health outcomes. The DMOs are required to measure outcomes and report results in an annual report due within 45 days following the end of the service year. These annual reports should demonstrate whether outcomes improved during the year. For example, annual reports should include information related to hospital admissions, emergency room visits, clinical outcomes for the specific disease, and clients' knowledge of their disease. (See Appendix A, Table A-2.) However, as of March 2001, only Coordinated Care Solutions, the diabetes DMO, and Positive Healthcare, the HIV/AIDS DMO, had submitted annual reports. [9] The two hemophilia DMOs had not submitted the required reports.

[8] For instance, the program administrator's position has been filled by two individuals and was vacant for two months in Fiscal Year 2000-01. Of the three RN consultant positions, only one has been continuously filled by the same individual since August 1999; the other two positions were filled by five persons from June 1999 to the present.

[9] The diabetes DMO report is a draft, not a final report. The HIV/AIDS DMO report was submitted in mid-March, and the agency has not verified the information contained in the report.

Further, the agency did not take steps to obtain annual reports from Integrated Therapeutics Group, the asthma DMO, which had operated for the longest period. Although the agency's agreement with Integrated Therapeutics Group specified reporting requirements, the agency did not enforce them, thereby missing an opportunity to assess the effectiveness of asthma disease management for MediPass clients. Instead, the agency contracted with a private consulting firm for $119,000 in April 2000 to determine the cost-effectiveness of the asthma disease management program.

While conducting the evaluation, the consulting firm learned that very few clients actually received services, which, in turn, limited its ability to evaluate the effectiveness of the program. However, results did indicate some improved outcomes and decreased costs for the clients who received services compared to clients who were eligible for the program but did not receive services. For example, the clients who received services spent an average of $117 per year less than the comparison group on prescription drugs. [10]

Barriers Impeding Program Success Continue to Persist

The agency has not adequately addressed barriers that could hinder success

Agency staff monitor DMO contracts each quarter primarily by checking DMO files for documentation. Agency staff also receive monthly and quarterly reports from the DMOs that contain information on enrollment, program services, and health care utilization. (See Appendix A, Table A-2.)

However, staff do not use these sources of information to help them recognize and address problems or barriers that could adversely affect success of the initiative. Nor do staff conduct field visits to observe how services are delivered and to interview providers and patients who should be receiving services. Due to this limited oversight, the agency failed to adequately address several barriers that we identified through our review. [11]

- The initiative serves only a small percentage of eligible MediPass clients.
- The initiative provides limited care management and lacks a preventive approach.
- The initiative does not have enough provider participation.

These barriers have impeded the success of Florida's disease management initiative.

Although expected to serve all eligible MediPass clients, the initiative has served from only 6% to 58% of the clients eligible for service. The agency uses claims data to identify MediPass clients who meet the disease criteria for eligibility in a specific disease management program. The agency provides a list of eligible clients to each DMO every month, along with clients' primary care physician information and when available client addresses and telephone numbers. DMO staff are responsible for contacting clients, enrolling them, and delivering services. However, as shown in Exhibit 4, the DMOs are only delivering services to a small percentage of eligible clients. When DMOs provide services to only a small proportion of eligible clients, it becomes difficult to attribute program results to the initiative.

Clients must receive services for disease management programs to be effective. Research studies show improved patient outcomes for patients who actively participate in disease management programs. For example, asthma disease management literature shows that disease management interventions can significantly reduce emergency room visits and improve asthma symptoms. However, only about 6% of the estimated 30,000 MediPass

[10] It is important to note that evaluation results were based on only 119 Medicaid clients who participated in the asthma disease management program.

[11] We reviewed DMO monthly and quarterly reports; conducted interviews with DMO staff including program administrators, nurses, and case managers; conducted interviews with MediPass providers and clients; and made site visits to observe program operations. The end-stage renal disease and congestive heart failure programs began in the fall of 2000 and were not included in our review.

clients eligible for asthma disease management actually received program services. [12]

Exhibit 4
The DMOs Are Not Delivering Services to All of the Clients Eligible to Receive Them

Disease State	Clients Receiving Services[1]	Estimated Number of Clients Eligible for Services	Percent Receiving Services
Asthma	1,730	30,000	**6%**
HIV/AIDS	1,161	6,000	**19%**
Diabetes	8,110	14,000	**58%**
Hemophilia	61	130	**47%**

[1] Enrollment numbers as of the end of January 2001.

Source: OPPAGA analysis based on enrollment information provided by individual DMOs and AHCA MediPass program staff.

Both agency and DMO staff attribute the low percentages of eligible clients being served to difficulties in locating eligible clients. Client addresses and telephone numbers are sometimes incomplete or outdated, a problem common to the transitory Medicaid population. Agency staff should continue to work with the DMOs to help locate clients and improve the accuracy of addresses and phone numbers. If eligible clients are using health care services, the DMO should be able to obtain this information directly from providers who have recently treated these clients.

Care management services are not comprehensive and do not emphasize a proactive approach intended to prevent lower-risk clients from becoming high-risk clients. One of the central features of successful disease management is coordination by a care manager because it enhances intervention effectiveness and promotes self-management. Effective care management includes involving clients in developing treatment plans and providing face-to-face interaction with clients. However, most clients enrolled in the agency's disease management programs receive little face-to-face contact with care managers, because the initiative delivers a majority of services by telephone, especially for the lower-risk clients. In addition, according to agency monitoring reports, care managers frequently do not develop individual treatment plans with clients.

The preventive approach to disease management presents an opportunity to alter the natural course of the disease and prevent or delay the onset of complications. However, DMO staff sometimes contact only lower-risk clients once a month or once a quarter to see if the client's health status has changed. Disease management literature indicates that education and prevention strategies can positively affect client behavior and foster knowledge of disease conditions. DMO staff, however, do not always verify that clients receive, read, and understand educational materials sent through the mail. By providing only minimal services to the lower-risk clients, the initiative does not emphasize a proactive approach that prevents lower-risk clients from moving into higher-risk levels.

Provider support and participation has been limited. Another important feature of successful disease management is provider support and participation. While all of the DMOs must provide services to MediPass physicians, participation by physicians is voluntary. During program start-up, many of the DMOs reported difficulty gaining physician cooperation. Moreover, we found that doctors and office staff serving MediPass clients enrolled in a disease management program often had little or no knowledge of the program. [13] Unless the initiative builds a comprehensive program that involves a high degree of provider participation, it will be difficult to realize cost savings and improved health outcomes.

[12] Based on the draft report by the private company contracted to evaluate the asthma disease management program, the asthma DMO may have served even fewer than 6% of the eligible clients.

[13] We interviewed doctors from the HIV/AIDS and diabetes programs and called 15 doctors offices that have clients receiving services from the DMOs.

Initiative Design Could Limit Success

Contracting with several companies can be inefficient and foster inconsistencies

As of March 2001, the agency had contracts with 6 DMOs to deliver disease management services, and the number of contracts could grow to as many as 15 as the agency expands the initiative to include the nine diseases specified by the Legislature. Contracting with multiple companies is inefficient and can foster inconsistencies in critical procedures among companies, thereby hindering success.

Contracting with several companies can create inefficiencies for both agency staff and MediPass providers. Monitoring of DMO contracts consumes considerable staff resources.[14] Staff currently monitor six DMOs, one each for diabetes, HIV/AIDS, end-stage renal disease, and congestive heart failure and two for hemophilia. If the agency continues to contract with companies for specific diseases, agency staff could potentially monitor from 12 to 15 DMOs.

Contracting with several companies can also create confusion for MediPass providers that potentially have to interact with a number of DMO representatives. It would be less confusing and more efficient if providers had fewer DMOs serving their patients. As the disease management industry has matured, many DMOs have begun to manage several chronic diseases instead of specializing in just one disease.

In addition, contracting with multiple companies can create inconsistencies in how the DMOs assess risk level and determine the level of services for clients. To determine the level of services clients should receive, DMOs conduct risk assessments to classify clients into high-, medium-, and low-risk levels. These risk assessments vary among the DMOs, with each DMO using different criteria to assess risk and determine needed services. For example, the HIV/AIDS program and one of the hemophilia programs base the level of services clients will receive solely on a clinical indicator.[15]

In contrast, other DMOs use standardized screening tools that consider lifestyle and psychosocial factors, medical claims, and clinical status. The diabetes disease management program considers medical costs most heavily, selecting clients with high medical costs for the more intensive services. By contracting with fewer DMOs, the agency would be more able to ensure equitable and consistent selection criteria for client services.

A holistic approach that is patient-focused rather than diseased-focused could better meet the multiple needs of Medicaid chronically ill clients

Florida's current approach to Medicaid disease management is disease-focused, providing services for specific diseases rather than using a patient-focused or holistic approach to providing services. Under this disease-focused approach, the initiative contracts with DMOs to manage care related to a specific disease. In contrast, a patient-focused or holistic approach is more comprehensive and would address the total health care needs of chronically ill clients by contracting with DMOs to manage patients rather than specific diseases.

Chronically ill individuals often suffer from more than one chronic condition (called co-morbidities) or experience health problems that are unrelated to their primary disease conditions. For example, HIV/AIDS patients can develop diabetes as the virus progresses. In addition, clients with diabetes sometimes also have sickle cell anemia, end-stage renal disease, congestive heart failure, or hypertension. In fact, Coordinated Care Solutions, the diabetes DMO, reports that 53% of MediPass clients with diabetes also have other chronic conditions. Even so, the agency, for the most part, contracts

[14] The monitoring process typically involves checking financial records, personnel files, client charts, and policies and procedures. Staff conduct the review either by a site visit or through the mail, depending on the location of DMO headquarters.

[15] The HIV/AIDS uses an immunological cell marker that indicates the body's ability to fight off infection. The hemophilia program uses one that indicates the blood's ability to clot.

with DMOs that specialize in specific diseases and that may not have the expertise to deal with clients' health issues unrelated to the specific disease managed by the DMO.

Further, the agency allows clients to enroll in only one disease management program even when clients have more than one chronic condition. To illustrate this, in the fall of 2000, the agency transferred clients enrolled in the diabetes program whose primary diagnoses was either end-stage renal disease or congestive heart failure to those respective programs, begging the question of how these programs will address the clients' diabetes related health problems. By shifting to a holistic approach, considering the person as a whole and focusing services to address all patient health care needs, the initiative is likely to achieve better client outcomes as well as lower costs.

The disease management industry is moving towards using a patient-focused approach. Some established disease management organizations have experience managing more than one chronic disease and offer programs that manage the total health care needs of the patient rather than a single disease. Further, health policy literature acknowledges that this shift towards a more patient-focused approach may be more effective than carving out and placing clients in programs that are disease-specific.

Conclusions and Recommendations

The 1997 Florida Legislature directed the Agency for Health Care Administration to implement a disease management initiative for Medicaid clients diagnosed with asthma, diabetes, hemophilia, or HIV/AIDS. In 1998, the Legislature directed the agency to expand the initiative by developing programs for hypertension, cancer, congestive heart failure, end-stage renal disease, and sickle cell anemia. In response, the agency established an asthma disease management program in August 1998, programs for diabetes, hemophilia, and HIV/AIDS in the summer and fall of 1999, and programs for end-stage renal disease and congestive heart failure in the fall of 2000.

Although the Legislature expected the disease management initiative to include programs for nine diseases, implementation has been slow, with only five of nine programs currently operating. The agency also has not yet determined whether the initiative has improved health outcomes or reduced costs, in part, because the agency did not establish an explicit methodology for determining cost savings prior to implementing the initiative.

Agency oversight has been minimal, failing to identify and address significant problems. In addition, multiple contracts have created inefficiencies for agency staff and MediPass providers and inconsistencies across the initiative in how the DMOs assess risk level and determine client services. Furthermore, the initiative design does not adequately address the multiple health issues of the chronically ill who often suffer from more than one chronic condition. We therefore recommend the Legislature take the actions described below.

- **Direct the Agency for Health Care Administration to redesign the disease management initiative from a disease-specific to a patient-focused or holistic approach.** A patient-focused approach addresses the person as a whole, considering co-morbidities and multiple health concerns. The disease management industry is moving towards a patient-focused approach. Several established disease management organizations deliver care management that is patient-focused addressing total health care needs and have experience with multiple disease conditions. Further, health policy literature as well as disease management representatives and agency staff recognize that a holistic or patient-focused approach may be more effective than a disease-specific approach.

  In addition, a patient-focused approach to disease management can be provided using fewer DMOs. Contracting with fewer DMOs will benefit the agency by

consuming fewer resources for contract monitoring. It will also ensure more consistency in patient services and less confusion for MediPass providers, thereby providing an opportunity for more provider participation.

- **Require the agency to establish a defensible methodology to determine cost savings and ensure that overpayments are recovered.** To avoid potential conflicts and expedite cost-saving analyses, the agency should establish a valid methodology for determining cost savings that is explicitly described and included in all future contracts. In addition, to reduce the potential for overpayment, the monthly advanced fees to the DMOs should more accurately reflect the number of clients receiving services.
- **Require the agency to report on initiative progress in meeting performance expectations, including health outcomes and cost savings.** While the long-term impact of disease management should not be evaluated prematurely, the agency should assess and report initiative progress in a timelier manner. The agency should take steps to ensure that the DMOs submit annual reports containing the health outcomes information required by the contracts. These reports should be completed no later than four months after the end of the service year. This timeframe allows for claims processing lag times.

  The agency should also improve its oversight of the initiative by doing more comprehensive monitoring and using monitoring information along with DMO monthly and quarterly reports to identify impediments to program success. Adequate oversight is particularly important in the early years of an initiative. Had oversight been more comprehensive, the agency may have recognized and addressed problems related to service delivery such as DMOs providing few services to lower risk clients and MediPass providers having little or no knowledge of the initiative.
- **Require OPPAGA to complete a second review of the initiative by December 31, 2002, that reports on whether legislative expectations regarding cost savings and program outcomes are met.** This subsequent review should focus on initiative design and implementation as well as evaluate whether disease management is an appropriate tool for saving money and improving health outcomes of Medicaid clients.

Agency Response

In accordance with the provisions of s. 11.45(7)(d), *Florida Statutes*, a draft of our report was provided to the Secretary of the Agency for Health Care Administration for his review and response.

The Secretary's written response is reprinted herein beginning on page 14. The attachments cited in the written response are not included here, but are available upon request or may be found at OPPAGA's website.

OPPAGA provides objective, independent, professional analyses of state policies and services to assist the Florida Legislature in decision making, to ensure government accountability, and to recommend the best use of public resources. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021 or 800/531-2477), by FAX (850/487-3804), in person, or by mail (OPPAGA Report Production, Claude Pepper Building, Room 312, 111 W. Madison St., Tallahassee, FL 32399-1475).

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Appendix A
Florida's Disease Management Initiative

Often persons that have chronic diseases receive fragmented care between primary care physicians and specialty physicians and have difficulty following appropriate treatment plans, including prescription drug regimens. Treatment plans for chronic diseases, for which optimal guidelines exist, frequently vary from patient to patient and from provider to provider. These factors ultimately lead to expensive specialty treatment, inappropriate health care utilization, and negative health outcomes.

However, the high rate of complications experienced by patients with chronic illness could be prevented or reduced in frequency and severity through disease management. The Legislature directed the agency to implement disease management using

- best practice and treatment guidelines;
- prevention and education interventions;
- coordination of patient care;
- clinical interventions and protocols; and
- outcomes research and information technology.

Disease management uses an integrated approach to delivering health care so that better health outcomes and lower costs are achieved for the chronically ill. Florida's Medicaid disease management initiative contracted with disease management organizations to deliver a variety of patient, provider, and community outreach services highlighted in Table A-1.

Table A-1
Disease Management Should Offer a Variety of Services to MediPass Clients and Providers

Patient Services	Provider Services	Community Outreach
▪ Educational materials specific to the disease process ▪ Patient risk assessments to determine risk level ▪ Care management provided by a RN or LPN care manager ▪ Individual care plans ▪ 24/7 toll-free telephone services ▪ Patient satisfaction and knowledge surveys	▪ Best practice guidelines ▪ Recipient care plans ▪ Feedback on patient compliance with treatment protocols ▪ Patient profiling of utilization and cost patterns ▪ Specialist referral options ▪ Professional educational conferences ▪ 24/7 toll-free telephone line	▪ Health fairs

Source: OPPAGA review of DMO contracts and interviews with agency staff.

Measuring clinical, financial, health status, and satisfaction outcomes is a key component of disease management. Florida's initiative requires the DMOs to collect and report outcomes and submit them to the agency monthly, quarterly, and annually. Table A-2 highlights these outcome measures.

Table A-2
DMO Contracts Require Periodic Reporting on Client Outcomes

Monthly Reports	Quarterly Reports	Annual Reports
▪ Enrollment/ disenrollment by severity level ▪ Complaint logs ▪ Number of recipient contacts by severity level	▪ Enrollment/disenrollment by severity level ▪ Number of patients in each severity level ▪ Total number of days enrollees spent in each severity level ▪ Number of recipient contacts by severity level ▪ Results of baseline patient knowledge and satisfaction surveys ▪ Number of emergency room visits by severity level ▪ Number of hospital admissions, readmissions, and hospital days by severity level ▪ Case studies describing successful outcomes and barriers to successful outcomes ▪ Aggregate report of provider profiling information ▪ Quarterly project expenditures	In addition to reporting the outcomes specified in the quarterly reports for the year, the annual reports should contain clinical outcome measures specific to each program. Following are examples for four disease states: ▪ *Hemophilia:* Number of patients with the ability to self-infuse ▪ *Asthma:* Patient pulmonary function rates ▪ *Diabetes:* Number of glycosolated hemoglobin values within normal range ▪ *HIV/AIDS:* Average CD4 value Average viral load value

Source: OPPAGA review of DMO contracts and interviews with agency staff.

Appendix B
Status of Initiative as of March 2001

In 1997, the Florida Legislature directed the Agency for Health Care Administration to implement the disease management initiative for Medicaid's chronically ill individuals with asthma, diabetes, HIV/AIDS, and hemophilia. The following year, the Legislature directed the agency to continue the initiative and implement disease management for congestive heart failure, end-stage renal disease, sickle cell anemia, cancer, and hypertension. Table B-1 highlights the initiative's progress in implementing disease management. Table B-2 shows the total payments the Disease Management Initiative made to the DMOs.

Table B-1
As of March 2001, the Disease Management Initiative Is Implemented Only Partially

Disease State	Is the Program Currently Running?	How Many DMOs	Date Services Began	Is the Program Statewide?
Diabetes	*YES*	1	May 1999	*YES*
HIV/AIDS	*YES*	1	August 1999	*NO*[1]
Hemophilia	*YES*	2	September 1999	*YES*
Congestive Heart Failure	*YES*	1	September 2000	*NO*[2]
End-stage renal disease	*YES*	1	September 2000	*YES*
Asthma	*NO*[3]			
Hypertension	*NO*			
Cancer	*NO*			
Sickle cell anemia	*NO*			

[1] Not provided in Broward and Dade counties.

[2] Not provided in the 15 counties covered by Medicaid Areas 8-11.

[3] Services were provided statewide by one DMO beginning in August 1998 and ending January 15, 2001.

Source: Agency for Health Care Administration.

Table B-2
Through February 2001, the Disease Management Initiative Paid the DMOs $24.1 million

Disease Management Organization	Disease State	Total Advanced Payments
Coordinated Care Solutions, Inc.	Diabetes	$13.6 M
Positive Healthcare Florida	HIV/AIDS	$5.1 M
Caremark, Inc.	Hemophilia	$44,100
Accordant Health Services	Hemophilia	$84,800
LifeMasters, Inc.	Congestive Heart Failure	$1.9M
Renal Management System Disease Management Inc.	End-stage renal disease	$3.4 M
Total		**$24.1 M**

Source: Agency for Health Care Administration.

Appendix C
Agency Response

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., SECRETARY

May 7, 2001

Mr. John W. Turcotte, Director
Office of Program Policy Analysis
and Government Accountability
111 West Madison Street, Room 312
Claude Pepper Building
Tallahassee, FL 32399-1475

Dear Mr. Turcotte:

Thank you for the opportunity to respond to the preliminary and tentative findings and recommendations included in your justification review of the Medicaid Disease Management Initiative. Please find enclosed our response to the report recommendations made to the Legislature, and our response to statements found in the report narrative that we found to be in need of clarification or explanation.

If you have any questions regarding this response please contact Rufus Noble at 921-4897 or Kathy Donald at 922-8448.

Sincerely,

/s/
Ruben J. King-Shaw, Jr.

RJKS/kd
Enclosure

2727 Mahan Drive • Mail Stop #1
Tallahassee, FL 32308

Visit AHCA Online at
www.fdhc.state.fl.us

Agency for Health Care Administration
Response to OPPAGA's Justification Review of the
Medicaid Disease Management Initiative

Agency Response to OPPAGA Statements in the Report Findings:

OPPAGA Statement - page 1, paragraph 2:
In February 2001, the agency backed off making a vendor repay $7.6 million because the agency did not establish an explicit method to measure cost savings before contracting for disease management services.

Agency Response:
The agency did not "back off" making a vendor repay $7.6 million. Additionally, the agency established a method to measure cost savings that was included in the vendor contract (see attachment 1.) The method was agreed to by the vendor upon acceptance of the contract, and was employed by the agency to bill the vendor for the repayment of advanced administrative fees.

Upon receiving the notice for the repayment of the fees (see attachment 2), the vendor raised concerns regarding a specific factor utilized in the methodology. This factor, which is noted on page 22 of attachment 1, was used in the projection of anticipated costs for a diabetic population. As a result of the contractor's concerns, the agency agreed to re-examine the calculation for the initial repayment notice and rescind it with the understanding that a replacement notice would be sent upon the finalization of the re-examination (see attachment 3). This action by the agency was taken pursuant to a contractual provision that allows for adjustment to the baseline payment if mutually agreed upon by the agency and the contractor. Additionally, while the agency agreed to delay the call for repayment, the agency contractually retained the ability to conduct the cost reconciliation regardless of contractor agreement on adjustments.

The re-examination by the agency resulted in revision to the original calculations; however, the final outcome did not change the amount of the vendor's repayment obligation. A new letter requesting repayment of the advanced administrative fees was subsequently sent to the contractor (see attachment 4.)

OPPAGA Comment

OPPAGA believes that had the agency established a more explicit method for determining DMO cost savings, DMOs would be less likely to challenge results (when not in their favor) and request re-examination of calculations. It is also OPPAGA's understanding that during the "re-examination" period, the agency ran several analyses, each resulting in different baseline amounts depending on varying assumptions. Since baseline calculations are fundamental to determining cost savings attributable to disease management, developing a solid methodology prior to contracting should reduce the number of instances in which the agency rescinds requests for repayment.

2

OPPAGA Statement - page 5, paragraph ~~3.~~

The agency did not establish and include in the DMO contracts an explicit methodology for determining cost savings prior to implementing the disease management initiative. This makes the agency vulnerable to disputes over whether or not savings are achieved

Agency Response:

The agency established and included in each DMO contract a methodology for determining cost savings. It is true that the agency did not develop a cost savings methodology prior to initiating procurement for the disease management vendors. Because of the rapid development of the initiative and the infancy of the DM discipline, the agency believed the best approach would be to leave the cost savings methodology, along with various other components of the program, subject to review and determination throughout the procurement. For this reason, the agency issued an Invitation to Negotiate (ITN) for the DMO vendors. In accordance with the agency Contract Manual, an ITN is issued when the scope of work cannot be defined by the agency. This often occurs for acquisitions of rapidly changing technology outsourcing or complex services. We believed that the DM initiative met the criteria for issuance of an ITN.

The agency developed the cost savings methodology during the negotiation process with the potential vendors, some of which had prior DM experience. This approach resulted in a cost savings methodology that is included as an attachment to each DMO contract. The attachment addresses establishment of a baseline payment, the cost savings calculation and the distribution of shared savings, if applicable (see attachment 5 for an example.)

The agency disagrees with the statement that the approach taken makes the agency vulnerable to disputes. The cost savings methodology for the DM program is subjective and complex. As such, the methodology will be subject to continuing improvement and revision while working with the DM vendors. Any contractual provision can be challenged, and this approach of including the cost savings methodology in each DMO contract does not make the agency any more vulnerable to disputes than if the methodology had been fixed before DM implementation began.

Finally, the OPPAGA report provides only a general overview of the existing methodology employed by the agency. It does not reflect that contractual language has grown increasingly more "explicit" with each subsequent generation of DM procurement.

OPPAGA Comment

OPPAGA's position is that an "explicit" methodology should specify definitions and rules, particularly those related to establishing the baseline. While any contractor may choose to challenge contract provisions, OPPAGA stands by the premise that contractors will be less likely to dispute cost savings when the method used is valid, explicitly described, and included in contracts.

4

OPPAGA Statement - page 5, paragraph ~~5.~~

Even so, as of March 2001, the agency still has not determined cost savings, although the initiative has been operating for over two and one-half years.

Agency Response:

The agency is finalizing reconciliation for first-year service by four DMOs. It would be premature to report the specific savings before this process is concluded. Additionally, the agency is expecting

preliminary results from an independent evaluation of the disease management initiative to be available within the next few months.

OPPAGA Comment

OPPAGA recognizes that it would indeed be premature to report savings prior to finalizing the reconciliation process. However, OPPAGA's point is that since these programs have operated since 1998 and 1999, the agency should have (at the very least) completed this process for the asthma and diabetes programs by the end of 2000 and for the HIV/AIDS and hemophilia programs by early 2001.

OPPAGA Statement - bottom of page 5~~, top of page 6~~:
However, as of March 2001, only Coordinated Care Solutions, the diabetes DMO, and Positive Healthcare, the HIV/AIDS DMO, had submitted annual reports. The two hemophilia DMOs have not submitted the required reports.

Agency Response:
The statement is incorrect and misleading in that the term "only" suggests that all DMO providers were expected to provide annual reports by March 2001.

Of the hemophilia DMOs, one submitted an annual report in September 2000 (within deadline) and the second was under an approved extension at the time of the OPPAGA survey. No other contracted DMO was obligated to submit an annual report during this time period.

OPPAGA Comment

OPPAGA disagrees that the statement is misleading. Exhibit 3 and the preceding paragraph clearly indicate that this section of the report discusses the status of the DMOs that began delivering services in 1998 and 1999, not the DMOs that began delivering services subsequent to those years. With respect to the referenced report from the hemophilia DMO that submitted a report in September 2000, the report was incomplete and agency staff told OPPAGA that the agency would request the DMO to redo the report based on analyses of claims data once the DMO received these data. In addition, the September report was deficient in that it did not include some of the required elements and did not provide any evaluative comments related to how well the clients did in meeting the outcomes specific to hemophilia.

4

OPPAGA Statement - page 6, paragraph ~~5.~~
However, staff do not use these sources of information to help them recognize and address problems or barriers that could adversely affect success of the initiative. Nor do staff conduct field visits to observe how services are delivered and to interview providers and patients who should be receiving services. Due to this limited oversight, the agency failed to adequately address several barriers that we identified through our review.

Agency Response:
Since the DM initiative was implemented, the agency has conducted 21 on-site field visits to observe actual service provision by the disease management contractors, as well as conducting 8 desk reviews. This monitoring activity has addressed program operations and identified deficiencies related to each of the major barriers cited in the OPPAGA report. These areas included 1) recipient engagement/stratification, 2) recipient care management, and 3) provider outreach. Problems addressed, specific to results of on-site visits, are found in the agency-issued monitoring reports. The

monitoring reports include plans of action and subsequent follow-up visits by the agency. The monitoring reports also reflect the degree of fulfillment of contractual service requirements by the DMO, inclusive of service provision to the recipient and provider.

These monitoring reports were made available to OPPAGA.

In addition to the monitoring visits, review of routine reports and discussions with contractors resulted in specific actions to address identified improvement opportunities. For example, system changes in the Medicaid Eligibility Verification System have been implemented to allow Medicaid providers to determine a recipient's enrollment in the program at the time services are delivered.

OPPAGA Comment

OPPAGA's position is that the agency should improve its oversight of the disease management initiative. While the agency conducts quarterly contract monitoring visits of the DMOs located in the state and conducts quarterly desk reviews of the out-of-state DMOs, they have not been adequate. The agency's monitoring of the disease management initiative is, for the most part, compliance oriented and does not include visits to providers or interviews with clients to verify the level of services provided to clients. Further, even though the agency is aware of or at least not surprised by the barriers OPPAGA identified, the agency has not adequately addressed these barriers. If the initiative is to succeed, the agency must aggressively address barriers critical to success such as low provider involvement.

9 4

OPPAGA Statement - page ~~10~~, paragraph ~~5.~~

The agency also has not yet determined whether the initiative has improved health outcomes or reduced costs, in part, because the agency did not establish an explicit methodology for determining cost savings prior to implementing the initiative.

Agency Response:

As noted above, cost savings methodologies were included in each disease management organization contract. (see Agency Response to OPPAGA Statement - page 5, paragraph 2.) ~~3.)~~

The agency has looked to the contractual reports for documented measurement of improved health outcomes. There is early evidence of improved outcomes based on these reports. The agency submitted the reports to an independent evaluator. Given the experimental nature of this initiative, it may be too early to judge the hoped for positive results for both morbidity and program costs. The Legislature is to be commended for encouraging innovative approaches that may curb rising program costs while reducing morbidity.

OPPAGA Comment

OPPAGA concludes that the agency fell short of legislative expectations by not having determined, even for the earlier programs, whether the initiative has saved the state money or improved client health outcomes. Since 1997, the Legislature has reduced Medicaid appropriations in proviso by $112.7 million based on anticipated savings expected by this initiative. Not only has the agency not fully implemented the initiative, it has not determined the extent to which the disease management programs that have operated since 1998 and 1999 have improved client health outcomes or decreased costs. For these programs, with better initial planning, the agency could have assessed and reported on health outcomes and cost savings by the end of 2000.

Agency Response to OPPAGA Recommendations to the Legislature:

Recommendation - page 9:
Direct the Agency for Health Care Administration to redesign the disease management initiative from a disease-specific to a patient-focused or holistic approach.

Agency Response:
The agency has begun to consider the efficacy of disease-specific compared to a more population-based approach. As the discipline of disease management continues to evolve, so does the Florida MediPass Disease Management Initiative.

Looking to the disease management experience of both private and public organizations to serve growing populations of chronically ill individuals, more effective and resource-efficient strategies are sought. The agency receives calls from other state-based agencies looking to Florida to share what we have learned thus far. Florida is leading the nation in the development and implementation of disease management interventions for Medicaid populations.

Recommendation -page 10:
Require the agency to establish a defensible methodology to determine cost savings and ensure that overpayments are recovered
Agency Response:
As stated above, the cost savings methodology will continue to be refined as experience necessitates. The agency believes that the current methodology is defensible, and that no methodology will make the agency immune from potential challenges. To the extent authorized by law, the agency will ensure that overpayments are recovered.

Recommendation -page 10:
Require the agency to report on initiative progress in meeting performance expectations, including health outcomes and cost savings.

Agency Response:
The agency welcomes reporting requirements by the Legislature. The agency has been proactive in disseminating findings on the results of the disease management initiative, and has published annual reports on the progress of the initiative in 1999 and 2000, with the 2000 report included on the agency website. The agency anticipates issuing an updated annual report by July 1, 2001, which will allow for the inclusion of preliminary findings from the independent evaluation and completion of outstanding cost reconciliations.

Recommendation -page 10:
Require OPPAGA to complete a second review of the initiative by December 31, 2002, that reports on whether legislative expectations regarding cost savings and program outcomes are met.

Agency Response:
The agency welcomes the additional review by OPPAGA. Given that Florida is in the forefront of developing Medicaid disease management programs, it is important to carefully assess the impact of this initiative.

ATTACHMENT V

METHOD OF PAYMENT

A. Introduction.

1. This is a fixed price (unit cost) contract. The Agency will manage this fixed price contract for the delivery of services to enrolled members (service units) to be paid by the fiscal agent in accordance with the terms of this contract for a total dollar amount not to exceed $25,921,410, subject to the availability of funds. CCS is prohibited from billing the recipient for disease management services.

2. CCS will be paid by the Agency including a retrospective adjustment based on the level of savings that occurs when comparing the Agency's expected expenditures for CCS enrollees to the actual expenditures for CCS enrollees. The Agency will continue to pay submitted Medicaid fee-for-service claims through its fiscal agent for participating recipients. The Agency will reimburse Medicaid providers only for those services identified as compensable in the program specific Medicaid Coverage and Limitations handbooks.

B. Monthly Administrative Fee.

1. The Agency agrees to pay CCS for the service units (enrolled members) at the unit price and limits listed below.

Service Units	Unit Price	Maximum # of Units	Maximum Time
1. Enrolled members, *Medium/Low Risk	$41.25 per member per month	12,209 estimated members per month**	24 months of contract period
2. Enrolled members, *High Risk ***	$45.37 per member per month	12,208 estimated members per month**	24 months of contract period

*Number of members in the two risk categories are estimations since changes in a member's disease condition may cause movement between risk categories during the contract.

**CCS will implement the disease management project in 3 phases during the first 12 months of the contract period.

***The high-risk population will be defined by the CCS Patient Screening Scorecard.

These funds will be a "draw down" against CCS's share of anticipated cost savings. The purpose of this fee is to help CCS invest in administrative activities (e.g. care management, education and outreach) that present short-term costs but long-term savings to the Agency.

Unless this contract is extended or renewed, no disease management services will occur during the third contract year and, therefore, no monthly administrative fees will be paid during the third year of the contract.

2. The total amount of monthly fees will vary from month to month based on enrollment levels. The administrative fees will be paid to CCS through the Medicaid fiscal agent on a monthly basis.

3. The Agency will verify the enrollment list monthly. All known adjudications to any prior month's administrative fees (due to findings of enrollment list reviews) shall be made in the form of adjustments to an ensuing month's administrative payment.

4. For each of the three years of the contract, the Agency does not intend for total actual payments (paid claims plus administrative fees) for enrolled recipients to exceed the total baseline payment. However, if the total actual payments exceed the baseline payment, CCS will refund previously received administrative fees to the Agency, as necessary, so that the Agency's total actual payments do not exceed the total baseline payment. In a worst-case scenario, CCS would refund all administrative fees received from the Agency. CCS will submit payment to the Agency within 90 days of notification that a refund of monthly payments is required.

5. The Agency shall not pay a monthly administrative fee for a recipient automatically enrolled in the CCS disease management project should a CCS assessment indicate a recipient does not have diabetes, is enrolled in CMS or is not eligible for any other reason(s).

C. Shared Savings.

1. CCS may receive payment in the form of shared savings. Savings available to be shared is the difference between actual Agency payments on behalf of CCS enrollees (Medicaid claims payments including MediPass case management fees) and the baseline payment.

2. Establishing the Baseline Payment:

   (a) The baseline payment reflects an estimate of the level of MediPass recipient costs that the Agency would expect to incur in the absence of implementing the disease management initiative. The baseline payment will be derived from a claims analysis involving eligible MediPass recipients. These recipients will meet the Agency's criteria for having characteristics of diabetes.

   (b) For the identified recipients, the number of MediPass recipient case months will be calculated for the 1997-98 fiscal year (defined as the baseline period). All paid claims for these recipients, while enrolled in MediPass, will be aggregated to determine total expenditures for the baseline period. The number of case months and the paid claims will be excluded for those months when recipients are in

categories ineligible for disease management services. These expenditures will be divided by the total number of case months for recipients eligible for diabetes disease management to obtain a dollar expenditure amount per recipient per case month. This dollar expenditure amount per recipient per case month will be inflated based on yearly Medicaid budget adjustments and will be referred to as the baseline payment per recipient case month. This will be used in the calculation of the baseline payment.

(c) Fiscal year 1997-98 dates of service will be used to establish the baseline payment for CCS's first operational year. Fiscal year 1998-99 dates of service (or the most current available fiscal data) will be used to establish the baseline payment for CCS's second operational year.

(d) The parties agree that the purpose of such a baseline is to measure comparable costs that include like populations, geographic locations and cost components. Accordingly, the parties agree to use their joint best efforts to assure that the baseline cost calculation and all subsequent calculations are comparable in terms of the characteristics of the populations, geographic locations, the cost components and services included in the calculations and disease categories used to compute them. As necessary, the parties may mutually agree to adjust either the initial baseline calculation, subsequent baseline calculations and the costs included under the diabetes management project, in order to assure such comparability.

3. Cost Savings Calculation:

(a) Paid claims of all recipients enrolled with CCS will be identified. Only claims with service dates during periods of CCS enrollment will be used.

(b) Paid claims will be aggregated to determine the expenditures for the identified recipients for all Medicaid service categories.

(c) Total cost savings will be calculated as follows:

1. CCS's baseline payment for the contract year, which includes MediPass case management fees paid to primary care providers
2. Minus all Medicaid paid claims made on behalf of CCS enrollees for dates of service during the contract year, which includes MediPass case management fees to primary care providers. Only claims incurred during periods of CCS enrollment are included in the calculation.

4. Shared Savings Payments:

(a) It is the intent of the Agency that the CCS portion of savings will be reasonable and related to CCS costs and not reflect a disproportionate share of the cost savings.

(b) If total cost savings exist in a given contract year, these savings will be shared with CCS as follows:

1. CCS will receive 50% of the savings until the savings reach a figure representing 15% of the per member per month (PMPM) baseline payment for the enrolled population;
2. CCS will receive 20% of additional savings above 15% of the PMPM baseline payment; and
3. Notwithstanding 4.(b)1., 2., CCS's total share of savings shall not exceed the lesser of: (a) 133% of the total budgeted expenses for the first two (2) years of the contract period, as reported in the revised budget submitted to the Agency by CCS to be $19,489,782.00, or (b) 133% of actual expenses incurred in completing the requirements of the contract.

(c) CCS shall submit quarterly expenditure reports within 45 days of the end of each quarter. The expenditure reports shall be in the same format as the revised budget submitted to the Agency and shall show expenditures for the quarter, as well as, a year to date total of expenditures.

(d) Medicaid staff will perform the necessary analysis in order to determine total cost savings, the total monthly administrative fees previously paid to CCS and the total amount that might be due CCS for the contract year. Medicaid staff will transmit this information (including a statement of methodology and utilization data) to CCS's Project Manager. If money is owed to CCS by the Agency, the Project Manager will submit an invoice to the Agency. If CCS owes the Agency money, the Project Manager will submit payment within 90 days of notification by the Agency.

(e) The Agency and CCS agree to meet every six months after the contract effective date to review the status, calculation and methodology associated with the shared savings provision.

D. Reconciliation.

1. To allow for the adjudication of Medicaid claims, factoring in the delayed submission of claims, the Agency and CCS shall conduct three payment reconciliations. Each reconciliation will have the following components:
   (a) the identification of a baseline payment;
   (b) the determination of whether cost savings exist;
   (c) the determination of the amount of CCS's share of cost savings, if any, that will be paid by the Agency to CCS; and
   (d) the determination of the amount, if any, that must be repaid by CCS to the Agency.

   (See Exhibit 1 to Attachment V for scenario examples illustrating C.4.(b)1.,2. and D.1.(a-d)).

2. The reconciliation for the first contract year will be made after the first quarter of the second contract year. Cost savings will be determined after an analysis of paid claims with service dates during months 4 through 12 of the first year's contract period, to allow for a three-month project start-up period. The total amount of paid claims will be adjusted to an annual amount. Although the first reconciliation will not include paid claims during the first three-months of the contract, the administrative fees paid during all twelve months of the contract year will be included in the reconciliation process. The amount owed to CCS will be calculated using the formula described within this contract. Reconciliation shall consist of determining whether the total amount of administrative fees paid to CCS is greater or less than the amount owed to CCS. If the amount owed to CCS is larger than the total administrative payments, the Agency will pay CCS the difference. If the total of the administrative payments is larger than the amount owed to CCS, CCS will pay the Agency 100% of the difference within 90 days of notification.

3. The reconciliation for the second contract year will be made after the first quarter of the third contract year. Cost savings will be determined after an analysis of paid claims with service dates during the second contract year. The amount owed to CCS will be calculated using the formula described within this contract. Reconciliation shall consist of determining whether the total amount of administrative fees paid to CCS is greater or less than the amount owed to CCS. If the amount owed to CCS is larger than the total administrative payments, the Agency will pay CCS the difference. If the total of the administrative payments is larger than the amount owed to CCS, CCS will pay the Agency 100% of the difference within 90 days of notification.

4. A final reconciliation will be made a year after the end of the second operational year to precisely adjudicate the final paid claims totals for applicable service dates during the first 24 months of the contract period and with payment dates encompassing all applicable months of the contract. The final reconciliation will have the same components as the first and second contract year reconciliations. If the amount owed to CCS is larger than the total administrative payments, the Agency will pay CCS the difference. If the total of the administrative payments is larger than the amount owed to CCS, CCS will pay the Agency 100% of the difference within 90 days of notification.

ATTACHMENT 2

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., SECRETARY

January 19, 2001

Ms. Virginia Dollard
CEO/President
Coordinated Care Solutions, Inc.
210 University Drive
STE 700
Coral Springs, FL 33071

Dear Ms. Dollard;

Enclosed you will find the Agency's reconciliation of the first year of the diabetes Disease Management Initiative (DMI). I understand that we will be meeting on Tuesday, January 23, 2001 to discuss any questions you might have on the reconciliation methodology. I wanted you to have a copy of the actual reconciliation with all the supporting documentation prior to the meeting.

I look forward to our getting together to discuss this. Please let my staff know if you have any special needs prior to that meeting so that they can be prepared in the meeting to expedite this process. As I have stated in the past this must be brought to a resolution in a timely manner.

Sincerely,

Bob Sharpe

Bob Sharpe
Acting Deputy Secretary for Medicaid

Coordinated Care Solutions / Diabetes
Year One Reconciliation
Contract Year: May 1999 - April 2000

Line #	Description	Billable Casemonths *	Year 1 PMPM	Year 1 Amounts
	COST SAVINGS CALCULATION:			
1	Baseline Payment *(Projected Payments absent any interventions)*	179,598	$809.81	$145,440,204.73
2	Actual Claims for Year of Intervention *(For CCS Enrollees)*	179,598	$839.55	$150,781,582.31
3	Cost Savings Available *(Line 1 minus Line 2)*		($29.74)	($5,341,377.58)
	SHARED SAVINGS CALCULATION:			
4	Sharing of Cost Savings *(If Line 3 is negative, enter zero)* *(If Line 3 is positive, enter 50% of Line 3)*			$0.00
5	Shared Savings CAP *(If Line 3 is negative, enter NA)* *(If Line 3 is positive, enter 15 % of Baseline Payment)*			NA
6	Additional Savings *(If Line 4 is > than Line 5, then Line 4 minus Line 5 * 20%)* *(If Line 4 is < than Line 5 or Line 5 is NA, enter zero)*			$0.00
7	Total Shared Savings *(The lesser of Line 4 or Line 5, Plus Line 6)*			$0.00
	RECONCILIATION OF YEAR 1:			
8	Total Amount Owed to Contractor / Year 1 *(Line 7)*			$0.00
9	Total Advanced Payments / Administrative Fees -Year 1 *(Per Payment History Report)*			$7,579,842.00
10	Difference *(Line 8 minus Line 9)*			($7,579,842.00)
	Amount Owed to Agency			** **$7,579,842.00**

* Does not include identified HIV / Aids Recipients

** Based on Pg 21 (4) the of contract, if the total actual payments exceed the baseline payment, CCS will refund previously received administrative fees to the Agency, as necessary, so that the Agency's total actual payments do not exceed the total baseline payment. In a worst-case scenario, CCS would refund all administrative fees received from the agency.

ATTACHMENT 3

STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., SECRETARY

February 8, 2001

Ms. Virginia Dollard
210 N. University Drive
STE 700
Coral Springs, FL 33071

Dear Ms. Dollard:

This is a follow up to our meeting on January 31, 2001 here in Tallahassee. As I indicated in that meeting it is not our intention to infringe our working relationship as it relates to seeking an equitable solution for the challenges of reconciliation. Yet, we must bring this to a timely resolution.

I appreciate your concerns related to the reconciliation methodology, and ongoing attempts to reach a mutually agreed upon conclusion to this process. Therefore, I am rescinding the Agency's reconciliation of the first year of the diabetes Disease Management Initiative sent to you on January 19, 2001.

We will continue to work toward appropriate adjustment of the initial baseline calculation. We anticipate that a revised reconciliation notice with be forthcoming. As I previously indicated in our meeting, there must be a timely conclusion to this process.

If you have any questions or I can be of further assistance to you, please do not hesitate to contact my staff or me.

Sincerely,

Bob Sharpe
Acting Deputy Secretary for Medicaid

ATTACHMENT 4
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certified
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STATE OF FLORIDA
AHCA
AGENCY FOR HEALTH CARE ADMINISTRATION

JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., SECRETARY

April 13, 2001

Ms. Virginia Dollard
President and CEO
Coordinated Care Solutions, Inc.
210 N. University Drive, Suite 700
Coral Springs, FL 33071

Dear Ms. Dollard:

Enclosed you will find the Agency for Health Care Administration's (Agency) final reconciliation notice for the first year of the diabetes Disease Management Initiative (DMI) that shows the $7,579,842.00 in administrative fees paid to Coordinated Care Solutions, Inc., due back to the Agency. This reconciliation replaces the one sent to you on January 19, 2001, and rescinded on February 8, 2001. The enclosed reconciliation makes an adjustment to the baseline payment calculations and adjusts actual claims payments for voids and adjustments in the pharmacy claims.

Please submit payment of the $7,579,842.00 to the Agency within 90 days of receipt of this letter.

Furthermore, the Agency plans for this diabetes disease management initiative to continue as outlined in the current contract. Service provisions under the contract will end April 30, 2001. The second year reconciliation will begin in September 2001, with the final reconciliation being in May of 2002. My staff will contact you as we finalize transition planning related to the ongoing management of recipients managed under the diabetes disease management initiative.

I want to thank you for your efforts on behalf of our recipients. If I can be of any further assistance to you, please do not hesitate to contact me at (850) 488-9347.

Sincerely,

Bob Sharpe
Deputy Secretary for Medicaid

BS/dr
Enclosure

Coordinated Care Solutions Diabetes
Year One Reconciliation Notice
Contract Year: May 1999 - April 2000

Line #	Description	Year 1 PMPM	Year 1 Aggregate
	COST SAVINGS CALCULATION:		
1	Baseline Payment Per Member Per Month *(Projected Payments absent any interventions)*	$786.53	
2	Payment on Claims Per Member Per Month *(For CCS Enrollees in Year 1*)*	$843.37	
3	Savings (Loss) Per Member Per Month *(Line 1 minus Line 2)*	($56.84)	
4	DMO Enrollment in Member Months *(For CCS Enrollees in Year 1*)*		179,598
5	Total Savings (Loss) on Paid Claims *(Line 3 multiplied by Line 4)*		($10,208,350.32)
	ADVANCED PAYMENTS - ADMINSTRATIVE FEES		
6	Total Administrative Advances to DMO *(For CCS Enrolless in Year 1)*		$7,579,842.00
	SHARED SAVINGS CALCULATION:		
7	Sharing of Cost Savings *(If Line 5 is negative, enter zero)* *(If Line 5 is positive, enter 50% of Line 5)*		$0.00
8	Shared Savings CAP *(If Line 5 is negative, enter NA)* *(If Line 5 is positive, enter 15 % of Baseline Payment)*		NA
9	Additional Savings *(If Line 7 is > than Line 8, then Line 7 minus Line 8 * 20%)* *(If Line 7 is < than Line 8 or Line 8 is NA, enter zero)*		$0.00
10	Total Shared Savings *(The lesser of Line 7 or Line 8, Plus Line 9)*		$0.00
	RECONCILIATION OF YEAR 1:		
11	Payment To (or Refund From) DMO		**($7,579,842.00)**

* Does not include identified HIV / AIDS Recipients

b. Shared Savings.

1. LifeMasters may receive payment in the form of shared savings. Savings available to be shared is the difference between actual Agency payments on behalf of LifeMasters' enrollees for the period of their enrollment in LifeMasters' services (Medicaid claims payments including MediPass case management fees) and the adjusted baseline payment.

2. Establishing the Baseline Payment:

   (a) The baseline payment reflects an estimate of the level of MediPass recipient costs that the Agency would expect to incur in the absence of implementing the disease management initiative. The baseline payment will be derived from a claims analysis involving eligible MediPass recipients. These recipients will meet the Agency's criteria for having characteristics of congestive heart failure presented in Exhibit 3 of Attachment I.

   (b) For the identified recipients, the number of MediPass recipient case months will be calculated for the 1997-98 fiscal year (defined as the baseline period for the first operational year of the contract) and for the 1998-99 fiscal year (defined as the baseline period for the second operational year of the contract). All paid claims for these recipients, while enrolled in MediPass, will be aggregated to determine total expenditures for the baseline period. The number of case months and the paid claims will be excluded for those months when recipients are in categories ineligible for disease management services. These expenditures will be divided by the total number of case months for recipients eligible for congestive heart failure disease management to obtain a dollar expenditure amount per recipient per case month. This dollar expenditure amount per recipient per case month will be inflated based on yearly Medicaid budget adjustments and will be referred to as the adjusted baseline payment per recipient case month. This will be used in the calculation of the baseline payments (see Exhibit 5 to Attachment I.)

   (c) Fiscal year 1997-98 dates of service are being used to establish the baseline payment for LifeMasters' first operational year. The FY 97/98 baseline will be adjusted forward three (3) years to determine the adjusted baseline for reconciliation purposes for the first year's contract operations (described below in the Reconciliation section). The FY 97/98 adjusted PMPM rate is $1,290.59 (please see Exhibit 5). The FY 98/99 baseline will be adjusted forward three years (to 01/02) to determine the adjusted baseline for reconciliation purposes for the second year's contract operations (described below in the Reconciliation section). The FY 98/99 adjusted PMPM rate will be determined at a later date (after all adjusting

factors have been applied to the baseline payment) and will be incorporated into the contract with a contract amendment.

3. Cost Savings Calculation:

(a) Paid claims of all recipients enrolled with LifeMasters will be identified. Only claims with service dates during periods of LifeMasters enrollment will be used.

(b) Paid claims will be aggregated to determine the expenditures for the identified recipients for all Medicaid service categories.

(c) Total cost savings will be calculated as follows:

(i) LifeMasters' baseline payment for each contract operational year, which includes MediPass case management fees paid to primary care providers minus,

(ii) All Medicaid paid claims made on behalf of LifeMasters' enrollees for dates of service during each contract operational year, which includes MediPass case management fees to primary care providers. Only claims incurred during periods of LifeMasters enrollment are included in the calculation.

4. Agency guaranteed savings and DMO shared savings payments:

(a) LifeMasters will guarantee the Agency a fixed percent of the adjusted baseline PMPM costs as described in (c) (i) below. The 6.5% PMPM savings guarantee for the first operational year is $83.88. (Please refer to Exhibit 6 to Attachment I for the calculation worksheet.) The 6.5% savings guarantee for the second operation year will be determined at a later date (after all adjusting factors have been applied to the baseline payment) and will be incorporated into the contract with a contract amendment. The 6.5% savings calculation shall be applied to the FY 98/99 adjusted baseline PMPM expenditures for the second year of the contract.

(b) It is the intent of the Agency that the LifeMasters portion of savings will be reasonable and related to LifeMasters costs and not reflect a disproportionate share of the cost savings:

(c) The following illustrates how savings will be distributed as a result of this contract:

(i) LifeMasters shall guarantee to the Agency 6.5% annual savings against the adjusted baseline PMPM expenditures. The 6.5% savings calculation shall be applied to the FY 97/98 adjusted baseline PMPM expenditures for the first year of the contract and to the FY 98/99

adjusted baseline PMPM expenditures for the second year of the contract;

(ii) After the 6.5% guarantee has been met, the Agency will retain additional savings until the savings in excess of the 6.5% guarantee reaches a figure representing 100% of the administrative fees paid to LifeMasters for the enrolled population;

(iii) LifeMasters will receive 50% of additional savings after both the 6.5% Agency guarantee and the savings equaling 100% of paid administrative fees have been met, and;

(iv) Notwithstanding 4. (c), (ii) and (iii), LifeMasters' total share of savings shall not exceed the lesser of: (a) 33% of the total budgeted expenses for the first two (2) years of the contract period, as reported in the budget submitted to the Agency by LifeMasters to be $6,090,000.00 or (b) 33% of actual expenses incurred in completing the requirements of the contract.

(d) LifeMasters shall submit quarterly expenditure reports within 45 days of the end of each quarter. The expenditure reports shall be in the same format as the revised budget submitted to the Agency in 04/00 and shall show expenditures for the quarter, as well as, a year-to-date total of expenditures. With Agency approval LifeMasters may, without a contract amendment, present budget and expenditure reports with up to 10% different line item categories as long as the total amount remains the same.

(e) Medicaid staff will perform the necessary analysis in order to determine total cost savings, the total monthly administrative fees previously paid to LifeMasters and the total amount that might be due LifeMasters for the contract year. Medicaid staff will transmit this information (including a statement of methodology and utilization data) to the LifeMasters' Project Manager. If money is owed to LifeMasters by the Agency, the Project Manager will submit an invoice to the Agency, and the analysis will be considered as justification for the invoice. If LifeMasters owes the Agency money, the Project Manager will submit payment within 90 days of notification by the Agency.

5. Contract Amount:

The maximum contract amount, $8,099,700.00, is the sum of the: PMPM unit price of $125.00 x 2,030 estimated units (enrollees) for 24 months (contract period) which equates to $6,090,000.00 plus 33% of the LifeMasters' budget, $2,009,700. LifeMasters' share in the cost savings (up to 33% of the lesser of its total budgeted or actual administrative expenses) is contingent upon the company achieving PMPM cost savings in excess of the 6.5% savings guarantee to the Agency, plus the total administrative fees paid by the Agency.

This contract may be renewed on a yearly basis for no more than two (2) years beyond the initial contract (or for a period no longer than the term of the original contract, whichever is longer). Such renewals shall be made by mutual agreement and shall be contingent upon satisfactory fiscal and programmatic performance evaluations as determined by the Agency and shall be subject to the availability of funds. Each renewal shall be confirmed in writing and shall be subject to the same terms and conditions set forth in the initial contract.

C. **Method of Payment:**

Introduction.

This is a Unit Cost (Contingency Fee) contract not to exceed $8,099,700.00. The maximum contract amount equates to 133% of the LifeMasters budget (See Exhibit 4 to Attachment I). The unit cost is a PMPM rate of $125.00, which is based on the LifeMasters' budget (See Exhibit 4 to Attachment I). The maximum contract amount will allow for a share in potential cost savings between LifeMasters and the Agency. The maximum contract amount also limits the amount of a share in cost savings available to LifeMasters to 33% of its budget (See Exhibits 4 and 8 to Attachment I). The Agency will manage this Unit Cost contract for the delivery of services to enrolled recipients.

LifeMasters is prohibited from billing the recipient for disease management services. Notwithstanding Section 5.e. of the Medicaid Provider Agreement, both parties understand that these services are not billable to any other insurer or third party including the Medicare program. For Medicaid providers, excluding DMO providers, the Agency will continue to pay submitted Medicaid fee-for-service claims through its fiscal agent for participating recipients. The Agency will reimburse Medicaid providers only for those services identified as compensable in the program specific Medicaid Coverage and Limitations handbooks.

I. **COMPENSATION**

a. **Monthly Administrative Fee**

1. The Agency agrees to pay LifeMasters for the service units (enrolled recipients) at the unit price and limits listed below.

Service Units	Unit Price	Maximum # of Units	Maximum Time
1. Total enrolled members	$125 per member per month	2030 Estimated members per month*	24 months of contract period

*The Agency will remit monthly administrative fees to LifeMasters based on $125 PMPM for the total enrolled members.

**LifeMasters will implement the disease management project in three phases as described in Section A. I. c. 2. (a) – (c).

These funds will be a "draw down" against LifeMasters' share of anticipated cost savings. The purpose of this fee is to help LifeMasters invest in administrative activities (e.g. disease monitoring, coaching, care management, education and outreach) that present short-term costs but long-term savings to the Agency.

Unless this contract is extended or renewed, no disease management services will occur during the third contract year term (by anniversary of the contract effective date) of this contract and, therefore, no monthly administrative fees will be paid during the third year of the contract.

2. The total amount of monthly fees will vary from month-to-month based on enrollment levels. The administrative fees will be paid to LifeMasters through the Medicaid fiscal agent on a monthly basis.

3. The Agency will verify the Census List monthly. All known adjudications to any prior month's administrative fees (due to findings of Census List reviews) shall be made in the form of adjustments to an ensuing month's administrative fees.

4. For each of the three years of the contract, the Agency does not intend for total actual payments (paid claims plus MediPass provider management fees) for enrolled recipients to exceed the total adjusted baseline payment. However, if the total actual payments exceed the baseline payment, LifeMasters will pay the savings guarantee as described in Section C. I. b. 4. (c). (i). and will refund previously received administrative fees to the Agency, as necessary, so that the Agency's total actual payments (paid claims, MediPass provider management fees, and the DMO administrative "draw downs") do not exceed the total adjusted baseline payment. In a worst-case scenario, LifeMasters would pay the savings guarantee and refund all administrative fees received from the Agency. LifeMasters will remit payment to the Agency within 90 days of notification that a refund of monthly payments is required.

5. The Agency shall not pay a monthly administrative fee for a recipient automatically enrolled in the LifeMasters disease management project should LifeMasters or the Agency become aware that a recipient does not have congestive heart failure, is enrolled in Children's Medical Services or is not eligible for any other reason(s).

II. Reconciliation.

To allow for the adjudication of Medicaid claims, factoring in the delayed submission of claims, the Agency and LifeMasters shall conduct three payment reconciliations. Each reconciliation will have the following components:

1. the identification of a baseline payment;
2. the determination of the Agency's 6.5% savings guarantee for each year;
3. the determination of whether cost savings exist;
4. the determination of the amount of the Agency's savings and LifeMasters' share of cost savings, if any, that will be paid by the Agency to LifeMasters; and
5. the determination of the amount, if any, that must be repaid by LifeMasters to the Agency.

(See Exhibit 7 to Attachment I for scenario examples illustrating c.4. (c)(i)-(iv) 4. and II. 1-4)

a. First Contract Year

The reconciliation for the first contract year will be made after the first quarter of the anniversary of the first contract operational year. Cost savings will be determined after an analysis of paid claims with service dates during months 4 through 12 of the first year's contract period, to allow for a three-month project start-up period. The total amount of paid claims will be adjusted to an annual amount. Although the first reconciliation will not include paid claims during the first three-months of the contract, LifeMasters' administrative fees paid during all twelve months of the contract year will be included in the reconciliation process. The Agency's guarantee and any amount owed to LifeMasters will be calculated using the formula described in section C, I, b, 1 - 4. Reconciliation shall consist of determining the Agency guarantee, the total amount of administrative fees paid to LifeMasters, reimbursement to the Agency of any administrative fees paid to LifeMasters that are not covered by savings, if any, after the Agency's guarantee, and any additional savings to be divided between the Agency and LifeMasters described in section C, I, b, 1 - 4. If any amount is owed to LifeMasters, the Agency will pay LifeMasters the amount in accordance with F.S. 215.422. If the total of the Agency's guarantee plus any amount of the administrative fee payments are larger than the total savings, LifeMasters will pay the Agency 100% of the difference within 90 days of notification.

b. Second Contract Year

The reconciliation for the second contract year will be made after the first quarter of the anniversary of the second contract operational year. Cost savings will be determined after an analysis of paid claims with service dates during the second term based upon anniversary of the contract commencement date. The Agency's

guarantee and any amount owed to LifeMasters will be calculated using the formula described in section C, I, b, 1 - 4. Reconciliation shall consist of determining the Agency's guarantee, the total amount of administrative fees paid to LifeMasters, reimbursement to the Agency of any administrative fees paid to LifeMasters that are not covered by savings, if any, after the Agency's guarantee, and any additional savings to be divided between the Agency and LifeMasters described in section C, I, b, 1 - 4. If any amount is owed to LifeMasters, the Agency will pay LifeMasters the amount in accordance with F.S. 215.422. If the total of the amount of Agency's guarantee plus any amount of the administrative fee payments are larger than the total savings, LifeMasters will pay the Agency 100% of the difference within 90 days of notification.

c. Final Reconciliation

A final reconciliation will be made a year after the end of the second operational year to precisely adjudicate the final paid claims totals for applicable service dates during the first 24 months (excluding the first three months of the first contact year), of the contract period and with payment dates encompassing all applicable months of the contract. The final reconciliation will be conducted using the process described above in Section II. a. and b. If any amount is owed to LifeMasters, the Agency will pay LifeMasters the amount in accordance with F.S. 215.422. If the total of the amount of Agency's guarantee plus any amount of the administrative fee payments are larger than the total savings, LifeMasters will pay the Agency 100% of the difference within 90 days of notification.

D. Special Provision:

a. Waiver.

No covenant, condition, duty, obligation, or undertaking contained in or made a part of the contract shall be waived except by written agreement of the parties, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity not withstanding any such forbearance or indulgence.

b. Conflict of Interest.

The contract is subject to the provisions of Chapter 112, F.S. LifeMasters must disclose the name of any officer, director, or agent who is an employee of the State of Florida, or any of its agencies. Further, LifeMasters must disclose the name of any state employee who owns, directly or indirectly, an interest of five