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Part I. Introduction and Overview

As part of the Agency for Health Care Administration’s (the Agency) mission to promote “Better Health Care for all Floridians,” this Comprehensive Quality Strategy (CQS) report documents priorities and goals that guide the delivery of Medicaid services in Florida. Consistent with the Agency’s primary focus on improving health care throughout the State, while also streamlining operational processes and providing transparency and accountability, this report:

- Details the methods and metrics for assessing program performance
- Describes quality improvement activities and results
- Highlights achievements and opportunities for improvement in state fiscal year (SFY) 2018-19

While the Florida Medicaid program has historically engaged in quality improvement activities for various components of the Medicaid program, this document presents an integrated quality strategy that serves as the framework to guide and improve outcomes in all elements of service delivery.

The Agency recognizes the importance of community and state partnerships to drive efficient, quality health care. We work with a diverse range of partners, leveraging experience and cultivating collaborations to address common goals. Stakeholders may include Medicaid recipients, other state and local government agencies (e.g., the Department of Elder Affairs, the Department of Health, the Agency for Persons with Disabilities, and the Department of Children and Families), health plans, health care providers, community organizations and associations, advocacy groups, and the state’s External Quality Review Organization.

The Agency’s current priorities and goals of the Medicaid program are outlined in Part II of this document. Part III provides interim updates of the major activities and initiatives in progress to achieve these goals.

Part II. CQS Priorities and Goals

The matrix on page five of this report outlines the priorities of the Statewide Medicaid Managed Care (SMMC) Program. Related to each priority are specific, measurable goals for the program’s quality initiatives. The initiatives are designed to drive improvements in health outcomes in efficient, innovative, and cost-effective ways. Florida Medicaid strives to provide the highest quality care to all enrollees, regardless of their race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, or geographic location. Multiple considerations factor in the development and implementation of quality improvement projects. Florida Medicaid also considers social determinants of health, such as housing, transportation, and access to healthy food choices, in the assessment of access to appropriate health care services for Medicaid recipients.
The Agency has identified several key program goals for the new SMMC contracts (2018-2023), aimed at continued advances in health plan performance. These program goals are featured in the matrix on page six. The key goals are:

1. Reduce potentially preventable hospital events (PPEs)
2. Improve birth outcomes
3. Increase the percentage of enrollees receiving long-term care services in their own home or the community instead of in a nursing facility
4. Reduce potentially preventable dental-related hospital events and improve access to preventive dental services

The Florida Medicaid program regularly evaluates a multitude of quality and cost metrics to inform changes to the health plan contracts, program design, and oversight processes. This new contract period presents an opportunity to promote several aims of both state and federal partners.

Listed below the priorities and goals in the matrix are specific quality assurance and improvement initiatives in which Florida Medicaid is engaged. Many of these initiatives are inter-related and support and/or impact more than one priority and set of goals. Several important initiatives are described in detail in Part III of this document. Annual updates will reflect current/ongoing activities within each quality initiative to measure progress toward meeting the various CQS goals and priorities.

The information contained in this 2020 update reflects a dynamic, comprehensive strategy based on the full implementation of the SMMC health plan and dental plan contracts. As noted above, this CQS focuses on specific priorities and goals identified by Florida Medicaid and the quality initiatives in place to achieve them. The modular format of this report facilitates contributions by multiple units within the Division of Medicaid, frequent updates of current initiatives, and the addition of new initiatives. Ongoing updates will be posted to the Agency’s website and submitted to the Centers for Medicare and Medicaid Services in a timely manner.

Disclaimer: While the progress of many of the quality initiatives described in the CQS have been impacted by COVID-19, the Agency will describe the approach and efforts as originally designed, while also recognizing that modifications and adjustments may need to be made to the timeframes and scope post-COVID.
# Florida Medicaid
## 2020 Comprehensive Quality Strategy

**PRIORITIES:**
- Improve the recipient’s experience of care
- Improve the overall health of the Medicaid population
- Continue to bend the Medicaid cost curve

**GOALS:**

<table>
<thead>
<tr>
<th>Reduce Potentially Preventable Events (PPEs):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
</tr>
<tr>
<td>Readmissions</td>
</tr>
<tr>
<td>Emergency Department (ED) Visits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improve Birth Outcomes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Primary C-Section Rate</td>
</tr>
<tr>
<td>Reduce Pre-term Birth Rate</td>
</tr>
<tr>
<td>Reduce the Rate of Neonatal Abstinence Syndrome (NAS)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improve Access to Dental Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the percentage of children receiving preventive dental services</td>
</tr>
<tr>
<td>Reduce potentially preventable dental-related emergency department visits</td>
</tr>
</tbody>
</table>

| Increase the percentage of enrollees receiving long-term care services in their own home or the community instead of a nursing facility |

**CURRENT INITIATIVES:**

- PPEs Stakeholder Workgroup
- Discharge Planning Pilot
- ED Diversion Pilot
- Super-utilizer Pilot
- Housing Assistance Pilot
- Health Plan Performance Dashboard
- Managed Medical Assistance Physician Incentive Program (MPIP)
- Value-based purchasing initiatives
- Enhanced data sharing
- Improving follow-up after mental illness or substance abuse hospitalization
- Birth Outcomes Stakeholder Workgroup
- Florida Award Program for Safely Reducing Cesarean Sections
- Long-Acting Reversible Contraceptives (LARC) Initiatives
- Increase participation in Healthy Behavior programs
- My Birth Matters campaign
- Family Planning Waiver campaign
- Maternity home-visiting program
- SBIRT Screening
- Mothers in Recovery Hospital Pilot
- Maternity Bundled Payment
- ASTHO OMNI participation

- Reduce potentially preventable dental-related ED visits
- Increase member access to preventive dental services
- Reduce transportation barriers to dental services
- Increase outreach and follow-up with enrollees after dental-related ED visits
- Improve dental access for adults and children in Medicaid

- Ensure person-centered care planning for long-term care enrollees and their caregivers
- Quarterly case file reviews
- Home and Community-Based Settings Reviews
- Increase response rate for Medicaid Home and Community-Based Services CAHPS by 10% per plan each year
- Increase performance on MLTSS performance measures by two percentage points each year.
- Independent consumer support program
- Caregiver assessments

*State of Florida  
September 2020*
Part III. Initiatives Supporting Goals

Statewide Medicaid Managed Care (SMMC) Program 2013-2018

The State of Florida Agency for Health Care Administration (the Agency) operates a section 1115(a) research and demonstration waiver. This waiver authority allowed the Agency’s Medicaid program to transition to Statewide Medicaid Managed Care (SMMC) in SFY 2013-14. This change moved most recipients to a managed care delivery system and reduced the number of recipients in different health care delivery systems within Florida Medicaid. SMMC is designed to ensure improved coordination and quality of medical, behavioral health, dental, and long-term care for all enrollees. Even those enrollees who are dually eligible for both Medicare and Medicaid benefit from the enhanced coordination between their Medicare providers and their Medicaid health plan to ensure improved communication, provision of appropriate services, and continuity of care.

From 2013 to December 2018, there were two components to SMMC: The Long-term Care (LTC) Program and the Managed Medical Assistance (MMA) Program.

The Long-term Care program:

The Florida Medicaid LTC waiver consolidated five existing home and community-based services programs into a single LTC and home and community-based services waiver1 and began operations in one region of the state on August 1, 2013. By March 1, 2014 it was operating in all eleven regions. Florida Statutes outline rate incentives to “encourage the increased utilization of home and community-based services and a commensurate reduction of institutional placement.” (F.S. 409.983(5)).

Successful transitions from nursing facilities to the community require LTC health plans to develop and implement individualized, person-centered care plans for every LTC enrollee. Additionally, case managers must counsel enrollees about their options for transitioning to the community. To encourage integration between long-term care services and medical services, the Agency’s auto-assignment algorithm intentionally prioritizes assignment of an LTC enrollee to the corresponding managed care plan when possible (in the case of comprehensive plans offering both LTC and MMA services). Moreover, these contracts specify that the coordination of mixed services (services provided by both MMA and LTC) be integrated and coordinated by one case manager (LTC). Until December 2018, Florida Medicaid contracted with six LTC plans, all of which also provided MMA services, making them comprehensive plans.

Managed Medical Assistance program:

The MMA program was designed to ensure consumer protections and improve quality of care, ease of transition between health care providers, and improved access to care for recipients in many ways, including these requirements within the health plan contracts:

- Continuation of currently authorized services for up to 60 days until the new MMA plan’s primary care provider and/or behavioral health provider has an opportunity to review the enrollee’s treatment plan;

---

1 1915(b)(c) Long-term Care Managed Care Waiver, originally approved February 1, 2013 and renewed December 19, 2016
• Review and resolution of recipient complaints, grievances, and appeals as part of the rapid cycle response system;
• Healthy behaviors programs to encourage and reward members for engaging in actions to improve their personal health. Examples include a medically approved smoking cessation program, a medically directed weight loss program, and a medically approved alcohol or substance use recovery program;
• Reporting of audited health plan quality metrics that are used by the Agency to produce web-based consumer report cards to encourage recipients to compare the health plans available in their areas;
• Promoting health plan accountability by imposing specific financial consequences for failure to meet quality, customer service and financial standards;
• Performance improvement projects that target several key HEDIS\textsuperscript{2} measures and other metrics related to dental care and birth outcomes: preventive dental care for children, prenatal care, and well child visits in the first 15 months of life;
• Support consumer participation on Florida’s Medical Care Advisory Committee (MCAC) and other forums; and
• Annual independent validation of each health plan’s encounter data.

The health plans the Agency contracted with were selected through the state’s competitive procurement process to ensure that enrollees received care from the highest quality health plans, delivering the best value and service packages. Following a rigorous readiness review of each health plan, the MMA program started in three regions of the state on May 1, 2014 and was rolled out in all eleven regions by August 1, 2014.

At the end of the first five years of the Statewide Medicaid Managed Care (SMMC) program, there were 16 plans in the Florida Medicaid program devoted to the following populations:

• Ten of the plans provided only MMA services
• Six of the plans were Comprehensive LTC plans that provided both MMA and LTC services
• One of the Comprehensive LTC plans also served as a specialty plan for children in the Child Welfare system
• One plan served only dual eligible (Medicare and Medicaid) recipients
• Two MMA specialty plans served recipients with HIV/AIDS
• One MMA specialty plan served children with special health care needs
• One MMA specialty plan served recipients with Serious Mental Illness (SMI)

The shift from multiple delivery systems to SMMC included a greater emphasis on performance improvement and quality measurement. Prior to SMMC, there were discrete quality improvement activities for the various delivery systems, but much of the focus was on administrative processes. The SMMC program, through improved coordination of each member’s services and service providers, allowed an integrated, comprehensive quality strategy. The result of this person-centered approach deployed data-driven, focused, and systematic feedback to health plan contract managers, policy and clinical staff. The Agency’s independent External Quality Review Organization (EQRO) also provided technical assistance to health plans to support measurable improvement in their quality of service delivery and health outcomes for Medicaid recipients.

\textsuperscript{2} The Healthcare Effectiveness Data and Information Set (HEDIS) is used by over 90 percent of America’s health plans to measure performance on important dimensions of health care and service. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA).
Ongoing feedback and measures of Florida’s SMMC program are encouraging. In calendar year 2017, 55 percent of scores on quality measures for the MMA program were at or better than the national average, compared to 58 percent and 67 percent in calendar years 2018 and 2019, respectively. Survey data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) indicate that Medicaid recipients are more satisfied with their health plans than are individuals enrolled in commercial plans in Florida. Below are the results of a survey conducted in Spring 2018.

<table>
<thead>
<tr>
<th>2018 - % of Recipients Rating Their Plan 8, 9, or 10 out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>76% Medicaid MMA Plans</td>
</tr>
<tr>
<td>65% Commercial HMO</td>
</tr>
<tr>
<td>71% Commercial PPO</td>
</tr>
</tbody>
</table>

Below are the enrollee satisfaction results for 2019:

<table>
<thead>
<tr>
<th>2019 – Enrollee Satisfaction Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
</tr>
<tr>
<td>77%</td>
</tr>
<tr>
<td>85%</td>
</tr>
<tr>
<td>Highly satisfied with their health plan</td>
</tr>
<tr>
<td>88%</td>
</tr>
<tr>
<td>90%</td>
</tr>
<tr>
<td>Highly satisfied with the customer service they received</td>
</tr>
<tr>
<td>82%</td>
</tr>
<tr>
<td>83%</td>
</tr>
<tr>
<td>Usually or always easy to get needed care</td>
</tr>
<tr>
<td>83%</td>
</tr>
<tr>
<td>89%</td>
</tr>
<tr>
<td>Usually or always easy to get care quickly</td>
</tr>
<tr>
<td>LTC Enrollees</td>
</tr>
<tr>
<td>84%</td>
</tr>
<tr>
<td>Highly satisfied with their Case Manager</td>
</tr>
</tbody>
</table>

Managed care has also proven to be effective in transforming the long-term care delivery system by continuing to promote receipt of services in the community versus an institution. Since July 2013 (pre-SMMC), the number of Medicaid recipients in nursing facilities has declined from 50,122 to 43,303 (a 13.6 percent decrease), and the number of recipients receiving services within their community has increased from 34,124 to 54,886 (an increase of 60.9 percent).

**2018-2023**

Florida law mandates that SMMC health plans be re-procured every 5 years. In 2016, the Agency began the planning efforts to re-procure new contracts with health plans. Also, during this time, the Florida Legislature mandated that the Agency implement a separate Medicaid prepaid dental program for children and adults as part of the new SMMC program. During 2016 and 2017, Agency teams performed extensive analyses not only of the SMMC quality measures, but also recipient access and satisfaction with services, provider satisfaction, and health plans’ reporting and operational processes. This input was considered in the design and development of the new Invitation to Negotiate (ITN). While data and quality metrics from the first five years indicated that the initial SMMC program had improved quality, the ITN provided the Agency opportunities to strengthen areas where improvements could occur and to capitalize on new developments in technology and managed care service delivery.
The health plan ITN was structured to promote comprehensive care by ensuring that all recipients who were eligible for services under both the LTC and MMA programs could receive those services through one health plan. The ITN for the separate dental plans was designed to provide all dental services through managed care and laid out quality-related goals for the program, including reducing potentially preventable dental-related hospitalizations and visits to the emergency department.

Through the competitive procurement process, the Agency negotiated and selected health plans to provide MMA, LTC, and dental services to the more than 3 million Floridians enrolled in the SMMC program.

Resulting contracts were awarded to five health plan types:

**Comprehensive**: Provides MMA services and LTC services to eligible recipients.

**Long-Term Care (LTC) Plus**: Provides MMA and LTC services to recipients enrolled in the long-term care program. This plan type cannot provide services to recipients who are only eligible for MMA services.

**Managed Medical Assistance (MMA)**: Provides MMA services to eligible recipients. This plan type cannot provide services to recipients who are eligible for long-term care services.

**Specialty**: Provides MMA services to eligible recipients who are defined as a specialty population.

**Dental**: Provides preventive and therapeutic dental services to all recipients in managed care and all individuals in fee-for-service who have dental benefits.

The health plan ITN process resulted in contracts being awarded to seven Comprehensive Plans, one LTC Plus Plan, five MMA Plans, five Specialty Plans, and three Dental Plans. Three of the Specialty Plans are also providing services as Comprehensive Plans. SMMC health and dental plans and the regions they operate in are detailed in Appendix I.

The Agency's negotiation team, made up of subject matter experts in the field of Medicaid and managed care, negotiated the broadest benefit package ever available to Florida Medicaid recipients. During negotiations, health plans and dental plans committed to higher performance on the following Agency goals:

- Reducing potentially preventable hospital admissions, readmissions, and emergency department visits;
- Reducing rates of primary cesarean sections (C-section), pre-term deliveries, and babies born with neonatal abstinence syndrome;
- Increasing long-term care transitions to the community;
- Reducing potentially preventable dental related emergency department visits; and
- Improving children’s access to dental care.

The Agency’s negotiations with plans also resulted in gains for recipients and providers over the prior contract terms. For recipients, the new plan contracts include enhanced after-hours appointment availability, access to remote patient monitoring, and enhanced network adequacy standards. For providers, the new plan contracts allow for increases in value-based purchasing opportunities and reduced administrative burdens for high performing providers.

One of the biggest successes from negotiations was the enhanced benefit package available to Florida Medicaid recipients that for the first time included a variety of extra benefits. Expanded
benefits are benefits that are offered in addition to the standard benefit package offered by Medicaid and are provided by plans at no additional cost to the state. Examples include:

- **Health Plans**: Enhanced substance abuse and mental health treatment, alternative pain management services, housing assistance, cellular phone services, doula services, and vaccines for adults.
- **Dental Plans**: Preventive, diagnostic, restorative, periodontics for adults, oral and maxillofacial surgery, diabetic testing, practice acclimation for adults with intellectual disabilities, and special additional services for pregnant women.

A table of the expanded benefits that health and dental plans committed to provide in the SMMC program can be found in Appendix I.

**Performance Improvement Projects (PIPs)**

The Agency requires SMMC plans to implement Performance Improvement Projects (PIPs) aimed at improving specific areas of care. In the 2014-2018 health plan contracts, the Agency required plans to do a PIP focused on improving rates of Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life, as well as a PIP focused on improving rates of Preventive Dental Services for Children. Plans could select the focus of their other two PIPs with Agency approval. In the 2018-2023 contracts, the Agency is requiring plans to implement each of the following PIPs:

**Health Plans:**

- A combined focus on improving primary C-section rates, pre-term delivery rates, and neonatal abstinence syndrome rates.
- Reducing potentially preventable events including hospital admissions, readmissions, and emergency department visits.
- An administrative PIP focusing on the administration of the non-emergency transportation benefit, specifically focusing on the rate of trips resulting in the enrollee arriving to their scheduled appointment on time.
- A choice of PIP in one of two areas: behavioral health or integrating primary care and behavioral health.
- For all plans providing Long Term Care Services and Supports, interventions will focus on increasing the percentages of enrollees receiving long-term care services in their own home or the community instead of a nursing facility.

**Dental Plans:**

- Increasing the rate of enrollees under age 21 accessing preventive dental services
- Reducing potentially preventable dental-related emergency department visits in collaboration with the SMMC plans
- An administrative PIP focusing on coordination of non-emergency transportation services with the SMMC plans

While health plans are required to submit their PIP Summary Forms to the Agency annually, the Agency closely monitors the plans’ progress on a quarterly basis. Plans submit quantitative and qualitative reports on specific metrics requested by the Agency related to their PIP. Staff review the plans’ quarterly reports to ensure they are on track with their interventions and quickly
identify when an intervention is not having the intended effect. In addition, they must meet with their internal quality teams and steering committees throughout the year to track progress and provide updates on their performance measures and health outcomes of their members.

**Potentially Preventable Events**

As the state entity responsible for administering and overseeing Florida’s Medicaid program, the Agency is responsible for paying for and ensuring that Medicaid recipients - over four million children, low-income individuals, seniors, and individuals with disabilities who otherwise would have limited or no health insurance - receive appropriate and necessary quality medical services in a timely manner. The Agency must ensure access to health care amid growing costs in the United States and is continually seeking efficiencies and savings that do not compromise the quality of care.

One of the benefits of managed care is the potential to make health care more efficient by coordinating services for enrollees. Managed care has the potential to improve quality of care and reduce unnecessary use of healthcare resources by improving access to primary care, medication management, care transitions, and monitoring the use of health care resources.

The Agency has launched, in coordination with its health plans, several key initiatives focused on reducing potentially preventable hospital events. Some hospital admissions and emergency department visits are potentially preventable with improved access to primary care. Some hospital readmissions occur due to premature discharges, quality concerns during a previous hospital stay, or a lack of necessary services after discharge. By improving care during a hospital stay, more robust discharge planning, increased patient education about appropriate use of the emergency department, and continued follow-up by primary care providers (PCPs) and specialists, some hospital readmissions can be prevented.

The health plans committed to specific target reductions in PPEs for the next contract term (2018-2023). The chart below indicates the average reductions across all health plans for potentially preventable admissions, readmissions and emergency department (ED) visits over the next five-year period.

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially Preventable Admissions (PPA)</td>
<td>8.21%</td>
<td>2.92%</td>
<td>2.97%</td>
<td>3.11%</td>
<td>3.25%</td>
</tr>
<tr>
<td>Potentially Preventable Readmissions (PPR)</td>
<td>5.70%</td>
<td>3.15%</td>
<td>3.27%</td>
<td>3.22%</td>
<td>3.40%</td>
</tr>
<tr>
<td>Potentially Preventable ED Visits (PPV)</td>
<td>3.86%</td>
<td>2.77%</td>
<td>2.86%</td>
<td>3.05%</td>
<td>3.30%</td>
</tr>
</tbody>
</table>

Although not all PPEs can be avoided, PPE rates in populations can be used as a gauge regarding failure to access primary care and the quality of care available. Hospitalizations and emergency department visits tend to be costlier than outpatient or primary care visits. To the extent that PPEs can be reduced, health care can be more efficient and less costly.

The Agency has analyzed the first three years of claims and encounter data from the Managed Medical Assistance (MMA) program and produced reports which provide data on hospital admissions, readmissions, and emergency department visits that may have been prevented through improved self-management or access to primary care.
Below are findings from the most recent Winter 2019 Report:

**Potentially Preventable Hospital Admissions (PPA)** - Twenty-three percent (101,269/446,102) of all hospital admissions during the SFY 2017/2018 review period were identified as potentially preventable. Over 39 percent of PPAs were identified as potentially preventable because they could have been managed through outpatient coordination and over 38 percent could have been treated through the use of primary care. Heart Failure accounts for nearly 19 percent of the top ten conditions that resulted in a PPA, followed by Septicemia at 18 percent and Chronic Obstructive Pulmonary Disease (COPD) at almost 15 percent. The top ten conditions made up 60 percent of all the PPAs in SFY 2017/2018.

**Potentially Preventable Hospital Readmissions (PPR)** - About seven percent (37,867/539,900) of all hospital admissions were followed by a potentially preventable hospital readmission in SFY 2017/2018. Over three-quarters of PPRs were considered potentially preventable because they were due to complications related to care provided during the initial hospitalization or after discharge (27%), were a continuation or recurrence of a medical condition addressed in the original hospitalization (26%), or were a continuation or recurrence of a mental health or substance abuse condition following an initial hospitalization for substance abuse or a mental health condition (24%). The top three conditions for the initial admission that resulted in a PPR were Schizophrenia (16%), followed by Septicemia (15%) and Bipolar Disorders (15%). The top ten conditions leading to PPRs make up over 30 percent of all PPRs statewide.

**Potentially Preventable Emergency Department Visits (PPV)** - During the SFY 2017/2018 review period, 62 percent (1,507,264/2,424,631) of all ED visits were identified as potentially preventable. More than 31 percent of PPVs were considered potentially preventable because management of a chronic illness might have prevented the ED visit. About 54 percent of PPVs were considered potentially preventable because they addressed an acute illness (29%) or an acute infection (25%) that might have been treated in a primary care setting. Upper respiratory infections (URI) account for more than 23 percent of the top ten conditions leading to a PPV and 14 percent of all PPVs, followed by gastrointestinal disorders (14%) and abdominal pain (12%). Together these three conditions account for 50 percent of ED visits for the top ten conditions. The top ten conditions accounted for 63 percent of all PPVs in SFY 2017/2018.

Further details, including the full reports, are located on the Agency’s website at [http://ahca.myflorida.com/medicaid/Finance/data_analytics/BI/index.shtml](http://ahca.myflorida.com/medicaid/Finance/data_analytics/BI/index.shtml).
**Stakeholder Engagement**

Through extensive stakeholder engagement with hospitals, physicians, health plans, agencies, and associations, the Agency has developed a robust strategy for addressing PPEs. The chart on the next two pages details the pilot programs that are currently underway as a result of the stakeholder workgroup.

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Pilot</th>
<th>Overview</th>
<th>Location(s)</th>
<th>Timeframes</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| Potentially Preventable Admissions (PPA)| Provider Resource Toolkit and Outreach     | The purpose of this pilot is for Medicaid Health Plans to conduct targeted outreach to provider offices who have high rates of Potentially Preventable Admissions (PPAs). This pilot includes a provider pre and post assessment and toolkit of evidence-based resources. | Statewide   | 2020 - 2021 (6 month)| Increase number of members utilizing appropriate services  
Increase provider awareness of covered services  
Decrease in Overall PPA Rate  
Increase number of providers utilizing evidence-based recommendations (Asthma Action Plan, Tobacco Cessation Tools, SBIRT) |
| Potentially Preventable Readmissions (PPR)| Discharge Planning Pilot                   | The purpose of this pilot is to improve Medicaid members’ access to timely and appropriate services post-discharge. This pilot will entail weekly case round calls between providers, health plans, hospitals and others involved in the member’s care in order to develop treatment plans in real time. | Region 8 (Ft Myers) | 2020 - 2021 (1 year)| Increase number of members receiving timely and appropriate services  
Increase communication and collaboration among healthcare providers  
Decrease in PPR rate |
| Potentially Preventable ED Visits (PPV) | ED Diversion Pilot | The purpose of this pilot is for Medicaid Health Plans and hospitals to utilize the Emergency Department Information Exchange (EDIE) platform to improve timely notification of identified high risk members. This pilot will also include member education provided in the ED and incorporate the use of Federally Qualified Health Centers (FQHCs) as medical homes. | Region 1 (Pensacola) | 2020 - 2021 (1 year) | Increase number and percentage of pilot participants who obtain an appointment at a FQHC or other Primary Care Provider within 7 calendar days following an ED discharge. Increase use of Health Information Exchange (HIE) Platforms Decrease in the overall PPV rate | Region 7 (Orlando) |
To facilitate transparency and promote accountability, the Agency developed a publicly available dashboard that includes data related to PPEs. The dashboard allows users to look at rates of PPAs, PPRs, and PPVs statewide as well as by region, health plan, and hospital. It may be accessed online at:
https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityandPerformanceMeasuresDashboardSeries-20190923/SwitchboardPPEs?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no

Super Utilizers Pilot

The Agency is committed to transforming the health care system to increase accountability through improved health outcomes. In addition to activities aimed at reducing preventable hospital events, the Agency identified the need for an initiative surrounding a subpopulation of Medicaid members with very complex medical, physical, behavioral, and social needs. These high-cost, complex members are referred to as “super utilizers.” Because of their complex needs, these individuals typically have very high utilization of emergency departments (ED) and inpatient admissions. A super utilizer is defined as an individual who has been seen in the ED more than 12 times in a year.

To address this subpopulation, the Agency developed pilot projects in Tallahassee and Jacksonville focused on reducing over-utilization of the emergency department among Medicaid members, the Agency has partnered with health plans and local health systems to develop medical homes that will offer around the clock intensive case management to assist these high-risk members. These medical homes will be developing an interprofessional team of nurses, social workers, psychologists and community health workers to support every aspect of their assigned super utilizer’s needs and to be available to the member as needed, around the clock. The overall objective of the pilot is for super utilizers to be able to get all of the care they need at their designated medical home, rather than utilizing the ED when it may not be necessary. The duration of the pilot term will be one year with a future goal of expanding the pilot statewide.

Stakeholder Engagement

The Agency has been convening bi-monthly on-site meetings with stakeholders to identify barriers, evidence-based strategies and potential solutions to reduce the ED utilization and improve the health of super utilizers in the Florida Medicaid program.

Supporting Positive Birth Outcomes

The Agency’s birth outcomes initiatives aim to ensure quality care and safety for mothers and babies, with the goal of lowering maternal and infant morbidity and mortality rates. In alignment with the federal Centers for Medicare and Medicaid Services (CMS) Maternal and Infant Health Initiative, the Agency and contracted health plans are implementing evidence-based strategies and promising practices to improve perinatal and infant health.
The 2018-2023 contract requires health plans to implement Birth Outcomes Performance Improvement Projects (PIPs) to reduce primary C-section, pre-term delivery, and neonatal abstinence syndrome (NAS) rates. The following projects support the Agency’s goals previously outlined in the CQS. Progress will be monitored by looking at the rates for these three metrics (including process and outcome measures) annually and on a quarterly basis. The Agency will also monitor plan performance on any related HEDIS and Medicaid Child and Adult Core Set measures defined in Appendix II of this document to support the quality interventions implemented by the MMA plans. The following percentages are the average targets across plans that MMA plans have committed to achieving by 2023 to improve birth outcomes:

- Reduce Primary C-sections by 22%
- Reduce Pre-term Deliveries by 21%
- Reduce NAS by 14%

**Primary C-sections and Pre-term Deliveries**

In partnership with the Florida Perinatal Quality Collaborative (FPQC), the Florida March of Dimes, and Florida Department of Health (DOH), the Agency is actively working with its contracted health plans and other stakeholders to reduce primary C-sections and pre-term deliveries statewide. The Agency is focused on implementing the following primary C-section and pre-term delivery interventions:

- Conducting a My Birth Matters social media campaign to educate Florida consumers, specifically pregnant women, about the overuse of C-sections and to encourage safe deliveries and maternity care practices;³
- Collaborating with stakeholders in the development of joint quality improvement initiatives, the advancement of data-driven best practices and the promotion of education and training through FPQC’s PROVIDE 2.0,
- Conducting the Florida Award Program for Safely Reducing C-sections annually to commend hospitals who achieve the Healthy People 2020 goal of reducing C-section deliveries for first-time mothers with low-risk pregnancies at or below 23.9 percent. As of 2019, 13 hospitals received the award for two consecutive years. Partnering organizations expect an increase in hospital honorees in 2020;
- Expand the availability and use of doulas in the Medicaid program⁴;
- Increasing access to non-pharmacologic pain management therapies/treatment for women suffering with substance use disorder (SUD)⁵;
- Promoting the DOH universal prenatal and infant risk screening practices and recommending that health plans’ network providers use established screening tools;
- Improving access to maternity home-visiting services for high-risk pregnant and postpartum women through the utilization of the health plans’ covered benefits and federally recognized evidence-based home-visiting programs in the state;
- Increasing access to progesterone/progestin treatment (e.g., 17P) in diverse healthcare settings; and

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³⁵ Interventions support the FPQC Promoting Vaginal Deliveries (PROVIDE) 2.0 Initiative. AHCA and DOH launched the Florida Award Program for Safely Reducing Primary C-sections in October 2018 to highlight hospital quality improvement initiatives statewide. First-time, low-risk c-sections = nulliparous singleton vertex term (NTSV)
• Exploring alternative payment models for maternity care services that incentivize improved birth outcomes.

**Neonatal Abstinence Syndrome (NAS)**

Many national, state, and county-level organizations are focusing on NAS to raise awareness about babies prenatally exposed to opiates, alcohol and other illegal drugs. These organizations are designing strategies to address this critical issue impacting mothers and babies. In addition to increasing access to perinatal health services, there will be a comprehensive focus on ensuring access to postpartum and inter-conception care services. The Agency is partnering with key stakeholders to implement the following strategies to address NAS:

- Requiring MMA plans to use evidence-based screening, brief intervention, and referral to treatment (SBIRT) approach;
- Implementing system changes to include recommended federal billing codes for alcohol, drug screening, and brief interventions such SBIRT;
- Participating in the Association for State and Territorial Organizations (ASTHO) Opioid Use, Maternal Outcomes, and Neonatal Abstinence Syndrome Initiative (OMNI) project to address the opioid epidemic;
- Increasing access and referrals to SUD treatment (e.g., medication-assisted treatment (MAT)) for pregnant women; and
- Improving access to reproductive life planning options, including long-acting reversible contraceptives (LARCs) in diverse healthcare settings, and optimizing birth spacing through the promotion of birth plans and pregnancy intention screening tools.
- Collaborating on MORE Initiative to work with providers, hospitals, and other stakeholders to improve identification, clinical care and coordinated treatment/support for pregnant women with opioid use disorder and their infants.

**Stakeholder Engagement**

The Agency convenes monthly stakeholder workgroups to identify evidence-based strategies and potential solutions to improve birth outcomes through collective impact. The Agency has been working diligently to reduce barriers to accessing care, such as adopting Substance Abuse and Mental Health Services Administration guidelines for SBIRT billing, CDC guidelines for prior authorization requirements regarding buprenorphine prescribing for greater ease to access MAT for Medicaid eligible women of childbearing age, and configuring systems to allow doulas the opportunity to bill as a Medicaid provider.

Through extensive stakeholder engagement with physicians, health plans, hospitals, community organizations, and various associations, the Agency has identified a variety of strategies for improving birth outcomes. The table below outlines key projects and interventions underway:

<table>
<thead>
<tr>
<th>Project</th>
<th>Key Outcomes</th>
<th>Partners</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Birth Matters Campaign</td>
<td>• Increase consumer knowledge on safe deliveries&lt;br&gt;• Reduce unnecessary C-sections</td>
<td>DOH, FPQC, MMA plans</td>
<td>2020-2021</td>
</tr>
</tbody>
</table>
| Maternity Home-visiting Program | • Increase access to care for high-risk pregnant and postpartum members  
• Reduce pre-term deliveries | DOH, MMA plans, Healthy Start Coalitions | 2020-2021 |
| SBIRT Screening | • Improve early risk identification of substance used disorder (SUD) and opioid use disorder (OUD)  
• Reduce babies born with NAS | MMA plans, Providers, Healthy Start Coalitions | 2020-2021 |
| Mothers in Recovery Hospital Pilot | • Expand access to effective treatment and ongoing supports for sustained SUD treatment and recovery  
• Increase utilization of SUD treatment programs | Hospitals, MMA plans | 2020-2021 |
| Maternity Bundled Payment | • Improve perinatal health outcomes and reward providers for quality performance  
• Reduce primary C-sections and pre-term deliveries | Florida Alliance for Health Care Value, MMA plans | 2020-2021 |
| Florida Award Program for Safely Reducing Primary C-sections | • Meet/exceed the Healthy People 2020 NTSV target goal  
• Reduce primary C-sections | DOH, FPQC, FHA, Hospitals | Annual |
| ASTHO OMNI | • Increase access to MAT for pregnant women  
• Increase the number of providers actively prescribing MAT in line with standards of care  
• Increase access to buprenorphine by decreasing policy barriers, such as prior authorization | AHCA, DOH, DCF, FHA | Ongoing |

**Agency Success Stories – Birth Outcomes**

The Agency has successfully implemented the following activities to support and respond to feedback received from stakeholders:

- Developed an interactive Birth Outcomes data dashboard that is publicly available and allows users to look at rates of primary C-section, pre-term deliveries, and infants with NAS statewide and by region, health plan, and hospital. It may be accessed online at: [https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityandPerformanceMeasuresDashboardSeries-20190923/SwitchboardBirthOutcomes?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no](https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityandPerformanceMeasuresDashboardSeries-20190923/SwitchboardBirthOutcomes?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no);
- Included the generic brand of 17P on the Medicaid Preferred Drug List to increase access to progesterone therapies for women at risk of pre-term births which makes it easier for physicians to stock lower cost options for critical preventive treatment;
- Eliminated prior authorization for ongoing substance use and opioid use treatment for pregnant women;
- Achieved consensus with the health plans to reimburse immediate postpartum placement of LARCs separate from the labor and delivery DRG payment in diverse healthcare settings. This system change may contribute to better birth spacing and reductions in unintended pregnancy; and
Achieved consensus with the health plans to participate in the FPQC’s PROVIDE 2.0 and the Maternal Opioid Recovery Effort (MORE) quality improvement initiatives.

**Healthy Behaviors Programs**

Since January 1, 2015, SMMC health plans are contractually required to establish programs that incorporate evidence-based practices to encourage and incentivize healthy behaviors. At a minimum, each health plan must establish the following Healthy Behaviors programs:

1. A medically approved smoking cessation program that is evidence-based and recognized by medical professionals as an effective treatment method in addressing tobacco/nicotine dependence. The program may include interventions such as counseling and/or the use of medications (nicotine replacement products) as a part of the overall therapeutic process.

2. A medically directed weight loss program that requires ongoing supervision by a physician and may include the use of prescription drugs/supplements depending upon the need and goals of the enrollee, along with other physician-approved interventions (e.g., diet and exercise).

3. A medically approved alcohol or substance abuse recovery program that is evidence-based and recognized by medical professionals as an effective treatment method/approach. The program may include interventions such as medically assisted detoxification, medication and behavioral therapy, followed by treatment and relapse prevention as a part of the overall therapeutic process.

In addition to the Agency-mandated programs, many of the health plans have established optional Healthy Behaviors programs, which also provide incentives to members for engaging in and completing healthy activities and behaviors, as described below:

- **Diabetes Management** to reward members who complete tests and exams to better manage their diabetes.
- **Healthy Pregnancy** to reward members who join their health plan’s maternity program, including prenatal and postpartum care.
- **Well-Child Visit** to reward members who complete recommended exams and screenings.
- **Dental Visits** to reward members for completing an initial and timely six-month recall dental visit.

All Healthy Behavior programs are voluntary and require written consent from each participant prior to enrollment. Retail gift cards or points that can be converted into a monetary value are common incentives across the health and dental plans. Incentives are limited to a value of twenty dollars ($20) for completing a single activity and up to fifty dollars ($50) for completing a series of activities within a Healthy Behaviors program.

**Healthy Behaviors Program Oversight**
Plans are required to report quarterly data and annual evaluations on their Healthy Behaviors programs. The quarterly data reports capture program participation and completion rates by gender and age. In the annual evaluation, each plan must evaluate each Healthy Behaviors program in order to assess enrollee engagement (i.e., the number of enrollees participating), program completion rates, and health benefit outcomes/effectiveness. Results of the annual evaluation must be published on the plan website in addition to being submitted to the Agency. In the 2020-2021 Healthy Behaviors program year, the Agency will be convening a Targeted Monitoring focused on Healthy Behaviors programs with low enrollment numbers based on the quarterly data reporting. An analysis will be conducted on those plans’ outreach efforts to identify how the plans are reaching members that are eligible for a Healthy Behaviors program but are not yet enrolled. Plans will be required to submit identified barriers to enrollment as well as a plan for overcoming those barriers in order to increase enrollment. The Agency is also considering ways to incorporate individual-level data in the required quarterly reporting, to identify the impact or influence that Healthy Behaviors program participation has on health outcomes for members over time.

Housing Assistance Pilot Program

In April 2019, the federal Centers for Medicare and Medicaid Services approved an amendment to the 1115 MMA waiver for the Agency to create a Housing Assistance Pilot Program as part of the Florida Medicaid program. The goal of the program is to facilitate housing stability and improve health outcomes for up to 4,000 individuals with serious mental illness and/or substance use disorder who are homeless or at risk of homelessness. The pilot program is in Region 5 and Region 7, with four managed care plans participating. The program aims to improve health outcomes by helping individuals obtain stable and permanent housing through services traditionally not covered by Medicaid, such as transitional housing services; individual housing and tenancy sustaining services; mobile crisis management; and self-help/peer support services. The pilot program began operating in December 2019.

To assess the efficacy of the pilot, the Agency developed a set of performance measures that focus on monitoring the following health outcomes that plans are required to submit quarterly:

- Percentage of participants whose housing condition was upgraded or achieved permanent housing during the reporting quarter.
- Percentage of participants whose days of homelessness during the reporting quarter are reduced.
- Percentage of participants with a substance use disorder diagnosis who report no drug use or who have received medication assisted treatment (medication and behavioral therapy) in the past quarter.
- Percentage of participants employed or with increased hours worked during the past quarter.
- Percentage of reduced hospital admissions or readmissions among participants in the reporting quarter.
Value-Based Purchasing

In the 2018-2023 SMMC contract negotiations, health plans committed to increasing value-based purchasing arrangements. Plans have agreed to achieving performance targets, for each year of their contracts, related to the percentage of their members assigned to primary care providers with value-based purchasing (pay-for-performance) arrangements. While health plans may establish their own provider incentive programs and risk-based agreements with providers, all SMMC health plans are required to operate a Managed Medical Assistance Physician Incentive Program.

Managed Medical Assistance Physician Incentive Program (MPIP)

Beginning October 1, 2016, the Agency implemented the Managed Medical Assistance Physician Incentive Program (MPIP), which is designed to pay the equivalent of the Medicare rate to physicians who meet certain qualifying criteria, primarily associated with key access and performance measures. The expectation is that managed care plans will use effective care management to redirect available resources to pay physicians for all medically necessary services provided to the health plan’s Medicaid members under the age of 21, at rates which equal or exceed the Medicare rates for similar services. The Agency has identified Pediatric Primary Care Physicians (PCPs), Obstetrician-Gynecologists (OB/GYNs) and Pediatric Specialists as the provider types eligible for the MPIP payments.

MPIP Provider Qualification Process

SMMC health plans identify qualified physicians by October 1 of each year. To qualify for enhanced payments (i.e., payment at the Medicare rate), Pediatric PCPs and OB/GYNs must meet plan-specific access and quality criteria, such as:

- Patient-Centered Medical Home and Patient-Centered Specialty Practice Recognition
- NCQA HEDIS measures including Well-Child Visits, Children and Adolescent Access to Primary Care Practitioners, Lead Screening, ED Utilization, Postpartum Care
- Florida Medicaid Cesarean Section Rate

MPIP Oversight and Adherence

The Agency requires plans to submit semi-annual MPIP reports detailing the estimated reimbursement of individual physicians, actual payments made to the health plans’ qualified providers, and the number of enrollees served by qualified providers with enhanced payments. Additionally, the Agency routinely monitors the health plans’ compliance with MPIP-related responsibilities, including: the accurate identification of providers who qualify for the incentive payments; the provision of a reasonable opportunity for all identified providers to qualify for the incentive; and evidence to show that accurate payments are disbursed to qualified providers in a timely manner.
Quality Improvement Activities in the Long-Term Care Program

To ensure continued improvements in the delivery of the highest quality care to Florida Medicaid recipients, the Agency seeks to increase the percentage of enrollees receiving long-term care (LTC) services in the home and community as opposed to in a nursing facility. Florida statute requires that base reimbursement rates be adjusted to provide an incentive for plans to transition enrollees from nursing facilities to the community. The previous SMMC contracts required a transition incentive until just 35% of the LTC Medicaid population was in nursing facilities. The new SMMC contracts now require a transition incentive until no more than 25% of the LTC Medicaid population is receiving LTC services in nursing facilities.

In addition to the above target/goal, the LTC plans are required to focus on the following:

- Effectively transition enrollees to the least restrictive setting, also known as Home and Community-Based settings (HCBS). The goal is to have services started for the enrollees in their homes as quickly as possible to reduce any potential gaps in care. The SMMC contract specifies that the managed care plan shall start services for all in-home HCBS, for eighty-five percent of the applicable population within seven days of the initial face-to-face visit.
- Ensuring enrollees and their caregivers are involved in their care planning, including development of transition and care plans. This will require the increase in coordination and utilization of person-centered care planning.
- The Agency is focused on safely maintaining enrollees in the community settings, so there is a concentration on successful transitions. To ensure successful transitions for enrollees, the Agency has increased collaboration and partnership with hospitals, nursing facilities, and community stakeholders to ensure enrollees are connected to appropriate LTC services upon discharge. Since discharge planning starts at the time of admission, it is crucial for hospital discharge planners and managed care plan case managers to collaborate in order to ensure appropriate services are in place once the enrollee reenters the community.
- The Agency is also exploring opportunities for quality improvement in the area of reducing falls.

In order to successfully execute the quality initiatives outlined above, the Agency is working with stakeholders through a Long-Term Care workgroup and will continue to use stakeholder engagement to shape the Long-Term Care quality improvement strategy.

The Agency continuously monitors, tracks, and trends several required reports submitted by LTC managed care plans that focus on quality compliance for enrollees in the LTC program. The Agency focuses on LTC monitoring to track and trend the care of LTC enrollees and ensuring the sustainability of quality care within the home and community setting. The main areas of focus for monitoring compliance of the managed care plans are centered around the following:

- Ensuring case managers are meeting all contractual requirements in connecting LTC enrollees with high quality care providers and services, are not over-burdened by their caseload, are ensuring the enrollees are receiving all appropriate services in a timely manner, and that the services are of the highest quality of care.
- Identifying all incidents that occur in the home or community setting that negatively affect the enrollee's health or safety while in the care of home and community based providers,
ensuring these incidents are reported to the Agency, and that the health plan followed up properly to mitigate any future occurrences.

- Monitoring missed, denied, reduced, terminated or suspended LTC services to make certain they are not done so arbitrarily and are within the contractual requirements.
- Ensuring the physical location of all enrollees receiving LTC services is tracked for emergency and disaster planning, and all transitions into and out of the community are tracked and used for trending.

Quarterly, the Agency conducts an in-depth review of a sample of case files from each LTC plan. The purpose of this review of case files is to ensure the enrollees are receiving the highest quality of care from the health plans. Additionally, the Agency reviews case files to ensure care managers are consistently meeting all requirements so that enrollees don’t have any gaps in care or go without necessary LTC services. The case file reviews focus on quality compliance in the areas of:

- Timely completion of initial/annual comprehensive assessments.
- Timely and accurate Case Management and Care Coordination standards (e.g., timely communication and service initiation).
- Case Record requirements.
- Ensuring that the enrollee is directing their care and is able to enact freedom of choice of where services are received through a person-centered care planning approach.

In order to ensure compliance with the 1915(c) federal waiver requirements, the Agency will be assessing all contracted Home and Community-Based Settings that serve Medicaid recipients for home-like environments. The Agency is delegating the assessment of Home and Community-Based Settings to the managed care plans, who must conduct the assessments using the Agency-approved tool. The Agency validates the plans’ assessments using a combination of desk reviews and on-site visits. If any contracted HCBS settings are not in compliance, a remediation plan must be completed and submitted to meet compliance standards, or an evidentiary package explaining how the federal standards have been met under unique circumstances must be submitted. If a setting fails to meet compliance standards, action will be taken to transition Medicaid recipients out of that setting and into a home-like environment elsewhere.

These required report submissions allow the Agency to identify areas of improvement for the LTC program and LTC managed care plans. Data from these reports help to inform policy changes needed to ensure quality care for LTC enrollees.

**Part IV. Program Measurement and Monitoring**

**Health Plan Performance Measures**

Plans were required to report on 39 performance measures for calendar year 2018 services. Performance measures used to benchmark and compare Florida Medicaid health plans include:
The Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA)\(^6\) (e.g., the percentage of women who received their yearly breast cancer screening and the percentage of deliveries that received a prenatal care visit);

- Children’s Health Insurance Program Reauthorization Act (CHIPRA) Child Core Set measures\(^7\) (e.g., the percentage of children ages 6 to 9 years at elevated risk of dental caries who received a sealant on a permanent first molar tooth within the measurement year);
- CMS Medicaid Adult Core Set measures (e.g., the percentage of adults that were readmitted to the hospital within 30 days); and
- State-defined measures (used for areas of focus for which no national standardized measures are available - e.g., the percentage of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis that resulted in a readmission for a mental health diagnosis within 30 days).

Florida Medicaid also measures plan performance through surveys of enrollee satisfaction and experiences with health care and their health plan. These include annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys\(^8\) for Medicaid Health Plans and for Home and Community Based Services.

Florida Medicaid requires each type of health plan to report specified performance measures that align with the Agency’s goals and are relevant to the services it provides. For SMMC, the state has selected plan performance measures for the LTC plans and for the MMA plans. Specialty plans report particular measures that are relevant to the populations they serve. Please see Appendix II for a detailed list of performance measures health plans report on annually. The state continues to work with its External Quality Review Organization and various stakeholders to identify areas in need of improvement and the corresponding performance metrics and standards that may be targeted for inclusion in health plan contract requirements.

On an annual basis, the state reviews the performance measures that must be reported by the health plans to determine whether measures should be removed or added to the health plan reporting requirements. To promote accountability and transparency, as national standardized measures and technical specifications are developed, those measures are added in lieu of the state-defined versions so that data may be directly compared to other states and national benchmarks.

For calendar year 2018, continuing SMMC plans were required to report on four of the eight new Medicaid Managed Long-Term Supports and Services (MLTSS) quality measures developed for CMS by Mathematica Policy Research and its partner NCQA. These measures provide information about assessment and care planning processes among MLTSS health plan members that can be used by states, health plans, and other stakeholders for quality improvement purposes. For calendar year 2019, all SMMC comprehensive plans and the LTC plus plan reported on the eight MLTSS measures.

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\(^6\) For HEDIS measures for which NCQA calculates national Medicaid means and percentiles, the state has set the 75th percentile as the minimum standard for its SMMC health plans.

\(^7\) The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included provisions to strengthen the quality of care provided to and health outcomes of children in Medicaid and CHIP. CHIPRA required HHS to identify and publish a core measure set of children’s health care quality measures for voluntary use by State Medicaid and CHIP programs.

\(^8\) CAHPS surveys ask consumers to report on and evaluate their experiences with their health care and their health plan. CAHPS surveys are developed and maintained by the Agency for Healthcare Research and Quality (AHRQ) and included in HEDIS by NCQA. The Agency requires MMA plans to contract with NCQA-certified CAHPS survey vendors to conduct their surveys each year. Additional details about this survey are included in Appendix II of the Comprehensive Quality Strategy.
The Florida Medicaid program has historically evaluated and compared performance measure and survey data both at the statewide program level and at the individual health plan level. The state uses health plan level data for its Medicaid Health Plan Report Card9, which is available to Medicaid enrollees for use in selecting a plan. The current consumer report card includes audited10 HEDIS performance measure results. CAHPS survey results are also posted online for consumers to view11. In addition, Florida Medicaid collaborates with federal CMS to develop metrics for evaluating and comparing individual direct service providers or practice groups. Medicaid staff also solicit input from health plans regarding relevant metrics the plans are using to monitor their participating providers.

In addition to monitoring performance measures from its health plans and external quality reviews of them, Florida Medicaid contracts with several state universities to perform independent evaluations of various components of the program. With the shift to SMMC, the state has contracted for independent evaluations of the LTC program by a team at the Florida State University, and of the MMA program by a research team at University of Florida.

MMA Evaluation

The University of Florida conducts a program evaluation of the MMA 1115 Demonstration Waiver as required in the Waiver’s Special Terms and Conditions and in accordance with an evaluation design plan approved by CMS. The goal of the evaluation is to provide the Agency with an unbiased program evaluation that describes and analyzes recipient, service, and program characteristics.

The MMA program evaluation consists of ten (10) components, each with associated research questions. These components are:

- Component 1 – The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
- Component 2 – The effect of customized benefit plans on beneficiaries’ choice of plans, access to care, or quality of care;
- Component 3 – Participation in the Healthy Behaviors programs and its effect on participant behavior or health status;
- Component 4 – The impact of Low-Income Pool (LIP) funding on hospital charity care programs;
- Component 5 – The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care;
- Component 6 – The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals;
- Component 7 – The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner;
- Component 8 – The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services;
- Component 9 – The impact of the waiver of retroactive eligibility on beneficiaries and providers; and

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10 The National Committee for Quality Assurance (NCQA) licenses organizations and certifies selected employees of licensed organizations to conduct audits of HEDIS data using NCQA’s standardized audit methodology. The audit includes two parts: an overall information systems capabilities assessment, followed by an evaluation of the managed care plan’s ability to comply with HEDIS specifications. Additional details about this process are included in Appendix II of the Comprehensive Quality Strategy.
11 At http://www.floridahealthfinder.gov/HealthPlans/Default.aspx
Component 10 – The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD and are homeless or at risk of homelessness due to their disability.

The University of Florida subcontracts with two other universities to conduct some components of the evaluation (Florida State University and University of Alabama at Birmingham).

LTC Evaluation

An independent assessment is required for the first two renewal periods of the State’s 1915(b)(c) LTC Waiver Program. Florida State University has been contracted by the state to conduct the independent assessment. The focus of the evaluation projects for the independent assessment are as follows:

1. Project 1 - Access to Care: To provide a comparison of the LTC waiver programs and nursing facility services that were in place prior to the implementation of the LTC program to the LTC services available after the LTC program was implemented. The assessment will also compare changes in accessibility over time.

2. Project 2 - Quality of Care: To provide a comparison of the quality of LTC waiver programs and nursing facility services that were in place prior to the implementation of the LTC program to the quality of LTC services available after the LTC program was implemented. The assessment will also compare changes in quality of care over time.

3. Project 3 - Cost-effectiveness: To provide a comparison of the LTC waiver programs and nursing facility services that were in place prior to the implementation of the LTC program to the LTC services available after the LTC program was implemented. The assessment will also compare cost-effectiveness of LTC services over time.

Specific Metrics Support an Annual Comparison of Health Plans’ Quality Performance:

The Medicaid health plan contract requirements are designed to move the entire system of care toward higher quality through comparison of and accountability for each health plan’s performance. Annual comparison of the health plans’ results to specific thresholds and national benchmarks (when available) documents the performance of Florida Medicaid’s health plans relative to each other, and to national means and percentiles for other Medicaid programs around the nation. Florida Medicaid’s goal is for SMMC health plans to achieve the 75th percentile for all HEDIS measures, as listed in the NCQA’s National Means and Percentiles for Medicaid plans. Please see Appendix II for a detailed description of the methodology for comparing health plans’ quality metrics to specified benchmarks. In addition to the contractual requirements, to assess important facets of the new SMMC program goals, the Agency has placed an immediate focus on:

- Behavioral and Mental Health Services - The Agency monitors performance measures such as Mental Health Readmission to assess the percentage of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis that resulted in a readmission for a mental health diagnosis within 30 days.
- Improving Access to Dental Care - The Agency set incremental targets to improve the rate at which children receive preventive dental services. In FFY 2017-2018, 9 health plans met or exceeded the preventive dental services target rate of 39%. This 39% target was Florida Medicaid’s highest performance to date for preventive dental services and represents a 25-percentage point increase over the state’s rate of 14% in FFY 2011.
• Improving Birth Outcomes – The Agency uses measures to assess *Timeliness of Prenatal Care and Postpartum Care* as both components are instrumental in preventing poor birth outcomes.

Publication of HEDIS and CAHPS survey results and comparisons drive quality improvement by:

• Providing a means by which health plans can compare their performance and identify areas in which improvement is needed;
• Giving consumers the information they need to identify higher-performing health plans and to choose the plans that best meet their needs, thereby increasing market share for these plans;
• Providing a basis for assessment of liquidated damages, sanctions (which can include a moratorium on plan enrollment), and/or corrective action plans if minimum standards are not met by the health plan; and
• Providing a means for all stakeholders to compare the overall performance of Florida Medicaid and its health plans to other states’ Medicaid programs.

**External Quality Review Organization (EQRO):**

Pursuant to federal requirements related to quality review of Medicaid managed care programs, the Agency contracts with Health Services Advisory Group, Inc. (HSAG) as its EQRO vendor. Consistent with federal requirements12, the Agency’s contract with HSAG includes the following eight categories of activities:

• Validation of health plans’ Performance Improvement Projects;
• Validation of Performance Measures;
• Review of health plan compliance with Access, Structural and Operational Standards;
• Validation of Encounter Data;
• Focused Studies;
• Dissemination and Education;
• Annual Technical Report of compliance; and
• Technical Assistance on Other Activities.

Please see Appendix II for a more detailed description of EQRO activities.

**Enrollee and Provider Satisfaction Surveys**

Florida Medicaid also measures plan performance through surveys of enrollee and provider satisfaction and experiences with health care and their health plan. These include annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys13 for MMA and MMA Specialty Plans, an Integrated Behavioral Health survey for MMA and MMA Specialty Plans, Dental Plan CAHPS surveys for Dental Plans, and Home and Community Based

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13 CAHPS surveys ask consumers to report on and evaluate their experiences with their health care and their health plan. CAHPS surveys are developed and maintained by the Agency for Healthcare Research and Quality (AHRQ) and included in HEDIS by NCQA. The Agency requires MMA plans to contract with NCQA-certified CAHPS survey vendors to conduct their surveys each year. Additional details about this survey are included in Appendix II of the Comprehensive Quality Strategy.
Services CAHPS surveys for Long-Term Care Plans. In addition, the Provider Satisfaction surveys measure the providers’ overall satisfaction with the managed care plans.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey**

The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees’ experiences with health plans and their services. The Health Plan Survey 5.0 includes standardized instruments and optional supplemental items that are administered to adults and children enrolled in Medicaid and commercial health plans. The Medicaid questionnaire asks about experiences in the previous six (6) months. The CAHPS surveys results are due to the Agency by July 1 of each year.

The managed care plans are required to submit a written proposal for survey administration and reporting to the Agency annually for review and approval prior to fielding the survey(s). The proposal includes the plan’s CAHPS survey vendor’s NCQA certification, survey administration protocol, sampling methodology, analysis plan, reporting description, copy of the survey tool, and cover letters and/or postcards.

The Agency compiles all the plans’ adult and child CAHPS results and calculates the statewide rates. Individual plan rates and statewide rates are compared to previous years to see how the plans are doing each year and to track trends regarding different measures. The plans’ overall and individual results are posted publicly on the Florida Health Finder consumer healthcare transparency website every year so that consumers may use the information in selecting a Medicaid health plan.

**The Home and Community-Based Services CAHPS Survey**

In 2018, the Agency adopted the Home and Community-Based Services Consumer Assessment of Healthcare Providers and Systems (HCBS CAHPS) survey to be conducted by the Florida Medicaid Long-term Care (LTC) plans. The HCBS CAHPS survey measures the experiences of adult Medicaid recipients who receive HCBS through the LTC plans. The HCBS CAHPS survey must be administered in person or by telephone by an interviewer. It consists of 69 core items (103 total items) that ask LTC recipients to report on their experiences with the following:

- Getting needed services.
- Communication with providers.
- Case managers.
- Choice of services.
- Medical transportation.
- Personal safety.
- Community inclusion and empowerment.

The HCBS CAHPS survey was developed by CMS for voluntary use by state Medicaid programs to assess the experiences of adult Medicaid enrollees who receive long-term services.
and supports. English and Spanish versions of the survey tool are available. The HCBS CAHPS survey results are due to the Agency by September 1 of each year.

Survey administration guidelines for HCBS CAHPS include requirements that the managed care plans contract with an Agency-approved survey vendor certified by NCQA to administer CAHPS surveys. The survey must be administered telephonically or in-person. The survey sample includes only those enrollees who have been enrolled in the LTC plan and receiving home and community-based services for at least three consecutive months, and the minimum sample size is 2,000, with a target of 411 completed surveys. The LTC plan is required to have its sample validated by an NCQA-certified HEDIS Auditor.

The survey results are compiled, and statewide rates are calculated by Agency staff to see how plans are doing overall and individually. Individual plan rates and statewide rates are compared to previous years to see how the plans are doing each year and to track trends regarding different measures.

Provider Satisfaction Survey

In 2019, the Agency partnered with HSAG to create and develop a custom standardized provider satisfaction survey tool for use by Florida Medicaid managed care plans to assess the satisfaction of providers in the plans' networks. HSAG tested the survey tool through a pre-field test and pilot study in which providers gave feedback on the survey items. HSAG and the Agency revised the surveys based on provider feedback.

The survey was designed to provide the Agency and health plans valuable feedback on the physicians’ and office managers’ experience with plans’ provider relations and communications; authorization processes, including denials and appeals; timeliness of claims payment and assistance with claims processing; complaint resolution process; and care coordination/case management support. This will be the first-time plans use a standardized provider satisfaction survey tool, which will allow the Agency to more easily compare plans.

There are similar but separate provider satisfaction survey tools for providers in each plan type: MMA, LTC, and Dental.

Managed care plans are required to submit their provider satisfaction survey plans to the Agency for review and written approval annually. The proposal should include a copy of the Agency’s standardized survey tool including the plan’s name and current survey year; sampling methodology; and survey administration protocol.

The Provider Satisfaction Survey results are due to the Agency annually.

Integrated Behavioral Health Care Survey

The MMA plans must work in coordination with the Department of Children and Families (DCF) behavioral health managing entities to establish specific organizational supports and protocols that enhance the integration and coordination of primary care and behavioral health care services, in accordance with s. 409.973(6), F.S. Progress in this initiative is to be measured by using the integration framework and core measures developed by the Agency for Healthcare Research and Quality.
To meet the statutory requirement, the Agency is requiring MMA plans to conduct the Patient-Centered Integrated Behavioral Health Care Principles and Tasks Checklist Survey. The MMA plans must administer the survey to the 25 providers and/or provider groups selected as having the largest patient panels in their network. The Agency is providing de-duplicated lists of providers to each plan so that no provider receives the survey from more than one plan.

Quality Improvement Contracts

Quality Assurance Reviews for the Individual Budgeting Waiver

The Agency contracts with Qlarant to administer a Florida State Quality Assurance Program (FSQAP) for the Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver and the Consumer Directed Care Plus (CDC+) Program. Through an interagency agreement, the Agency for Persons with Disabilities (APD) is the state agency responsible for the operation of the iBudget Waiver and the CDC+ program. The iBudget Waiver provides home and community-based supports and services to eligible persons with developmental disabilities living at home or in a home-like setting. This waiver reflects the use of an individual budgeting model. The flexibility of the model allows recipients more opportunities to participate in determining service choices.

The goals of Qlarant’s quality assurance program are to assess the efficiency and quality of home and community-based supports, services, planning, and service delivery from the individual’s perspective, as well as to evaluate provider performance in delivering appropriate services and supports. Provider compliance with requirements in the Medicaid Waiver Services Agreement is also evaluated. In addition, the program provides training on the use of Qlarant’s information technology system(s) and review tools to providers, the Agency and APD staff, and APD providers through a web-based resource center.

The Agency works collaboratively with APD to implement a Quality Management Strategy (QMS) based on a close variant of the HCBS Quality Framework Model developed by CMS. Not only does this strategy provide an approach that is highly suited for Florida, its use assures future compliance with emerging federal requirements. This strategy is deployed by APD and assigns roles and responsibilities to all parties associated with the process.

The three quality management functions featured by QMS are discovery, remediation, and improvement. Although there is interactivity and connectivity between the three functions, it has been determined that the discovery activity is best suited for a contracted vendor (Qlarant), while the remediation function fits well with the APD regional office structure, and the improvement function is best performed at the APD headquarters level.

Discovery activities conducted by Qlarant’s QA program include the following two main components:

- Person Centered Reviews (PCRs) - The PCR monitoring process begins with a face-to-face interview with the individual receiving services. The review determines whether supports and services are adequate to achieve personally defined outcomes and whether the planning and coordination of services were delivered as the recipient had expected. A conclusion of findings addressing regions of deficiencies and opportunities for quality improvement in services and supports are provided and discussed with the
provider from the recipient’s point of view. The goal of the PCR is to improve quality of care and to ensure that all services are person-centered. Findings are also provided to the recipient. The targeted number of PCR reviews for FY 2019-2020 is 1,442.

- Provider Discovery Reviews (PDRs) – A PDR evaluates provider performance in delivering appropriate services and supports to assist the recipient in achieving personal goals (outcomes) and meeting identified needs. A conclusion of findings addressing regions of deficiencies and opportunities for quality improvement in services and supports is shared with the provider. Any provider that scores less than 100% on a PDR review has a mandatory remediation with APD. The provider meets with APD staff to discuss deficiencies and how the provider can improve for future reviews. A Plan of Remediation must be completed with the APD staff to ensure improvement in documentation and minimum quality standards. The targeted number of PDR reviews for FY 2019-2020 is 2,284.

In addition, an analysis of QA overall program findings is completed by Qlarant on a quarterly basis, with results provided to the Agency and APD. The analysis looks at significant review findings, identification of patterns and trends, and a summary of findings related to identified risks involving recipient health, healthcare, medical record reviews, safety, incident reports, and facilities observed.

Qlarant convenes quarterly Quality Council meetings that include recipients who receive developmental disability services, family members, Medicaid Waiver Providers, Waiver Support Coordinators, and other stakeholders. The purpose of the Quality Council meetings is to provide oversight of quality assurance activities conducted by Qlarant, to ensure compliance with contractual obligations, and to contribute feedback to the Agency and APD. The meetings provide a forum for discussion and development of recommendations that results in practical, useful information for stakeholders and meaningful quality improvement activities. The meetings also raise awareness of available community resources and community partnerships, which in turn expands resources for persons with developmental disabilities.

**Electronic Visit Verification**

The State of Florida has implemented Electronic Visit Verification (EVV) for both Home Health (HH) and Behavior Analysis (BA) services. For both HH and BA services, the EVV Program verifies the delivery of services using technology that is effective for confirming delivery of the service and deterring fraudulent or abusive billing for the service.

**Home Health Services:**

For fee-for-service (FFS) home health providers who render private duty nursing (PDN), home health visits (HH), and personal care services, the Agency has adopted an “open vendor” approach. This model allows providers the option to use the State’s contracted Vendor EVV system at no cost to them. Providers also have the option to continue using their own EVV third-party system in lieu of the Agency EVV system if approved by the Agency. However, the providers’ EVV third-party systems must be interoperable with the AHCA EVV claims system for billing purposes in order to be approved for continued use. The Agency this approach to allow flexibility and reduce administrative burden on providers.
The objective of the EVV program is to verify the delivery of services rendered by fee-for-service home health providers and deter fraudulent or abusive billing for the service. The EVV program’s mandatory go-live date was October 1, 2018, for all fee-for-service home health providers across the state.

- An average of 1,950 home health aides/caregivers utilize the EVV system monthly.

The Agency has also implemented EVV compliance requirements for managed care plans to ensure validation and monitoring of the delivery of HH services through the managed care plans’ EVV systems, effective January 1, 2020. The Agency requires managed care plans to report on EVV compliance through Agency prescribed monthly reporting on their validation, monitoring, and complaints logs.

**Behavior Analysis Services:**

For BA services, the Agency has contracted with a vendor to implement an EVV system and processes that hold BA providers accountable for the delivery of BA services to the Florida Medicaid fee-for-service recipient population. The program is designed to ensure recipients are receiving appropriate and prior authorized services timely from the assigned provider. The vendor’s EVV system includes a Smart Phone Mobile Application, Dashboard, and Claims Portal with an electronic billing interface.

Behavior Analysis providers who do not wish to use the vendor’s EVV system may use an EVV third-party integration option for approved interoperable systems. Third-party interoperability means that a BA provider who has an EVV system may continue to use it to capture and send EVV data to the vendor’s EVV claims system for billing.

The BA EVV program currently operates in Regions 9, 10, and 11. Starting December 1, 2019, providers were asked to participate in a soft launch of the BA EVV system to allow them the opportunity to become familiar with the system before its use becomes mandatory.

- Mandatory participation will be required beginning December 1, 2020.

**Fee-For-Service Utilization Management Activities**

The Agency has contracted with a certified Quality Improvement Organization (QIO), eQHealth Solutions, LLC to provide prior authorizations for a number of services paid for through the fee-for-service delivery system, including, but not limited to: inpatient hospital services, home health, therapy services, durable medical equipment and supplies, and behavior analysis services. The primary purpose of the QIO contract is to safeguard against the provision of unnecessary medical services or inappropriate use of Medicaid services and to ensure appropriate care.

eQHealth Solutions, LLC provides enhanced care coordination services for recipients under the age of twenty-one years who are enrolled in the fee-for-service delivery system and are receiving private duty nursing (PDN) or personal care services in their family home or other community-based setting, receiving services in a nursing facility, Florida Model Waiver services, or Prescribed Pediatric Extended Care (PPEC) services, regardless of plan enrollment. The care coordinator caseloads do not exceed forty recipients to one care coordinator for recipients receiving PDN services and fifteen recipients to one care coordination for recipients receiving services in a nursing facility.
Quality Monitoring Activities of MMA and Dental SMMC Programs

The Agency has the responsibility of monitoring managed care plan performance and providing oversight in all aspects of managed care plan operations. The Agency is also responsible for imposing liquidated damages resulting from failure to meet any aspect of the responsibilities of the SMMC contract and for imposing sanctions and/or requiring corrective actions for contract violations or noncompliance.

The Agency relies on two primary techniques to ensure that the managed care plans are providing high quality, medically necessary health care to the Medicaid population: (1) review of routine reports and submissions by the managed care plans, and (2) ad hoc targeted monitoring studies of the managed care plans for identified contract or covered service concerns.

Health Plan Required Reports and Submissions

The SMMC contract requires health plans to submit specified reports on a periodic basis. Many of the required reports focus on aspects of the provision of high-quality health care to Medicaid enrollees. The reports listed are reviewed for quality and clinical compliance. Any reports reflecting suboptimal performance by a health or dental plan may result in compliance actions, including corrective action plans or assessment of liquidated damages.

A detailed list of routine Monitoring reports, their primary purpose, and reporting frequency can be found in Appendix IV. Categories of reports are as follows:

1. **Provision of Primary Care:** There are several reports in this category (e.g., such as PCP Appointments, and ER Visits without PCP Appointments) that allow the Agency to monitor and track and trend the health plans’ focus on the promotion of primary care, preventative care, and chronic disease management. These reports are key drivers in achieving the Agency’s goal of reducing potentially preventable hospitalizations.

2. **Provision of Medically Necessary Cost Efficient Services:** Reports such as the Service Authorization Performance Outcome Report and the Inter-rater Reliability Report, allow the Agency to monitor and track and trend the health plan’s provision of all medically necessary services to Medicaid enrollees in a cost-effective manner, while assuring that service authorization decisions are made in a timely manner by qualified, trained staff.

3. **Protection of Vulnerable Populations:** Reports, such as the Residential Psychiatric Report, Enhanced Care Coordination, and Housing Assistance Rosters, allow the Agency to oversee that highly vulnerable Medicaid populations, such as medically complex children, frail elderly, and HIV patients receive appropriate case management to navigate the healthcare system and to receive appropriate medical services.

Targeted Monitoring Projects and Focused Reviews

The Agency’s historical monitoring techniques, which primarily focused on a review of the managed care plans’ policies and procedures, on-site interviews, and plan-wide reviews, have evolved into a more robust monitoring strategy. The revised monitoring strategy efficiently
focuses on identified issues, so that corrective action or actionable items can be employed to prevent or eradicate the noncompliance observed.

The Agency continues to make improvements to its quality initiatives and strategies through ongoing stakeholder engagement, robust monitoring strategies of managed care plans, and constant improvements to policies within the SMMC contract based on monitoring findings. Developing and participating in various stakeholder engagement activities such as behavioral health roundtable discussions, participating in quarterly calls with various stakeholder groups on specific topics to improve the quality of care for Medicaid enrollees, and working with managed care plans to make adjustments where needed have proven to be successful in the Agency’s overall quality monitoring of SMMC programs.

The Agency’s review of the health plan’s adherence to the contract requirements related to the prescribed drugs benefit (single preferred drug list) is an example of a targeted monitoring that was performed in 2019.

- **Preferred Drug List (PDL) Monitoring:** The Agency monitors plan adherence to the Agency preferred drug list (PDL). Plans are required to reimburse for drugs on the Agency’s PDL prior to alternative drugs requested by prescribers or recipients. Alternative drugs require prior authorization. Brand drugs are often preferred by the Agency over generic products due to negotiated rebates with manufacturers resulting in lower prices for the brand drug than the generic equivalent drug. Plans are not allowed to negotiate with manufacturers for rebates. In June 2019, the Agency monitored managed care plans’ compliance with the brand name drug preferred list for pharmacy claims with April 2019 dates of service. Plans were found to have PDL compliance rates between 70% and 100%. Managed care plans that did not meet 100% compliance were subject to compliance actions.

The target review process allows the Agency to be responsive to emerging trends, so the focus and priority areas of concern evolve over time as circumstances change. As an example, the COVID-19 pandemic created a need for a comprehensive monitoring of the health plans’ telemedicine services utilization and accessibility.

Each targeted monitoring project incorporates a series of steps and processes to successfully implement and execute project designs and timelines. This monitoring process is composed of the following phases:

- Information collection
- Project design
- Monitoring instruments development
- Intra-Agency coordination and collaboration
- Sample selection
- Health plan communication
- Data collection
- Data analysis
- Management reporting
- Feedback to health plans
- Potential remediation actions
- Contract/policy changes (if applicable)
Florida Health Information Exchange

The Agency is responsible for the implementation of the Florida Medicaid Electronic Health Record (EHR) Incentive Program (now known as the Promoting Interoperability Program), as established by Section 4201 of the American Recovery and Reinvestment Act of 2009. The program provides funding to support incentive payments to Eligible Professionals and hospitals for adopting, and the subsequent meaningful use of, certified electronic health records (EHRs) in order to promote the widespread adoption and use of EHRs. Participants in the program must meet the CMS meaningful use benchmarks, which include reporting on electronic Clinical Quality Measures (eCQM).

CMS released the Physician Fee Schedule final rule in November 2019. Pursuant to that rule, CMS has identified nine high priority eCQMs and has given each state the flexibility to identify if any additional measures from the available eCQMs selected by CMS for the Medicaid Promoting Interoperability Program are high priority measures for Eligible Professionals in that state. If additional high priority eCQMs are identified for Program Year 2020, the Agency will seek CMS approval through Florida’s State Medicaid Health Information Technology Plan.

The Agency is directed by statute to develop and implement a strategy for the adoption and use of electronic health records, including the development of an electronic health information network for sharing of electronic health records among health care facilities, health care providers, and health insurers. This statutory authority has allowed the Agency to develop a statewide health information network, known as the Florida Health Information Exchange (HIE), and to promote a variety of health information technology and exchange initiatives among Florida’s providers.

CMS funds the administration of the Medicaid EHR Incentive Program as well as the expansion of the health information exchange that improves interoperability for Medicaid providers.

Since its inception in 2011, the Florida HIE has grown to offer the following services:

- **Direct Messaging Service**: Agency outreach activities focus on encouraging providers to use the Direct Messaging capabilities included in their EHR. If providers are unable to do so, the Florida HIE provides Direct Messaging Services through a subcontract with Inpriva, a Direct Trust accredited Health Information Service Provider. Inpriva offers a mailbox service for providers without accessible EHR messaging services. This service allows for simple HIPAA-compliant, encrypted transmission of Protected Health Information.

- **Query Solutions**: The Florida HIE facilitates query-based exchange of electronic clinical data by providing a State Gateway to serve as an onramp to the eHealth Exchange. Organizations in Florida that cannot directly connect to the eHealth Exchange, or are not Carequality enabled, can partner with the Florida HIE to connect to the national exchange via the State Gateway.

- **Encounter Notification Service (ENS)**: Florida’s ENS provides subscribers with timely notifications about their members’ health care encounters. Utilizing data feeds from hospitals and skilled nursing facilities, information about a patient’s health care encounter (including demographic information, information on the source facility, and primary complaint) is securely sent to subscribers enabling them to immediately know when their patients have been admitted or discharged from any one of these connected facilities. Over 225 acute care and rehabilitation hospitals provide encounter data to the
ENS, covering 95% of Florida’s acute care beds and 86% of Florida’s rehab beds. There are presently over 12 million lives covered through ENS.

All Medicaid health plans and fifty-eight large Medicaid provider groups subscribe to ENS, covering millions of Medicaid lives across the state of Florida. Children’s Medical Services, a health plan and network of care administered by the Florida Department of Health for children with special health care needs from birth to the end of age 18, is also a subscriber.

With over 1.5 million notifications delivered monthly to subscribers, there are countless opportunities for Medicaid plans and providers to improve care coordination, reduce unnecessary hospital admissions, and improve the quality of care received by beneficiaries.

Notifications are provided through EHR integration, an SFTP site, Direct Messaging, or a lightweight interface that enables subscribers to manage their ENS notifications. The interface includes tools such as the Notes Entry feature, which allows members of a care team to document actions taken in response to particular ENS notifications.

The Florida HIE’s Encounter Notification Service supports the Medicaid Quality Strategy in a number of ways.

• Timely notification of hospital encounters can reduce potentially preventable events, especially unnecessary ED visits and hospital (re)admissions through care coordination by subscribers such as health plans, accountable care organizations, hospitals, and other providers.
• Timely notification of post-acute care encounters enables providers to better manage transitions of care and brings timely awareness to health plans of members who are discharged from a skilled nursing facility to a hospital.
• All statewide Medicaid dental plans subscribe to ENS and receive notification of dental related encounters at emergency departments. By subscribing to ENS, dental plans have the ability to educate patients on alternatives to ED use and set up follow-up appointments to avoid future complications and hospital readmissions.
• ENS supports positive birth outcomes by alerting care managers of obstetrical hospital admissions. This provides care managers the opportunity to educate patients and schedule postpartum care appointments prior to hospital discharge.
• ENS supports Care Coordination for Medically Complex Children though real time notification of encounters to health plans and providers caring for children with special needs.

In conjunction with the Agency’s mission to promote better health care for all Floridians, the Florida HIE strives to continually improve upon the services offered. Two major improvements that will support the Medicaid Quality Strategy are slated for the current fiscal year.

• Closing the gap in post-acute care coordination: In many instances, care managers are unaware of patient encounters at post-acute facilities, which can create the potential for hospital readmission. To address this issue the Florida HIE has worked diligently over the past fiscal year to onboard post-acute facilities. To date, the Florida HIE has onboarded 89 skilled nursing facilities and 16 rehabilitation hospitals as data sources to the ENS. Closing this gap in the post-acute care space has added tremendous value to ENS subscribers and their patients and the Florida HIE will continue to expand its reach into the post-acute care space during state fiscal year 2019-20.
• ED Access to Patient Acute Care Medical History: Key hospital partners have identified the need for ED staff to have more information about their patients’ acute care history.
To address this need, the Florida HIE will add a highly specific configuration to ENS that will provide ED physicians and staff with information on prior hospital encounters, giving them the much-needed historical context about their patient.

Summary

At the end of the first five years of the SMMC program, the Agency saw robust expanded benefits, enhanced provider networks, improved health outcomes, and high patient satisfaction. In 2019, the SMMC program continued to show some of the highest quality scores in Florida Medicaid's history. The results showed improvement in an overwhelming majority of quality measures. Florida’s Medicaid program is one of the most efficient programs in the country and serves as a national model. Ensuring that recipients have access to quality care has been the Agency’s top priority in the Medicaid program. By making continual improvements, the Agency is ensuring that more women than ever have access to prenatal and postpartum care, children are getting well-child visits, and adults have access to preventive care. With the roll-out of the second SMMC program, the Agency has secured commitments from the health and dental plans for continued improvement in many areas, including sustained improvement.
# Appendix I

## Health and Dental Plan Tables

### STATEWIDE MEDICAID MANAGED CARE (SMMC) HEALTH PLANS (2018-2023)

<table>
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<tr>
<th>REGION</th>
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<th>COMMUNITY CARE PLAN</th>
<th>FLORIDA COMMUNITY CARE</th>
<th>HUMANA MEDICAL PLAN</th>
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Comp = Comprehensive Plan  
MMA = Managed Medical Assistance Plan  
LTC+ = Long Term Care Plus Plan
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### Expanded Benefits

**Services that are covered in addition to your current benefits**

#### Contact the plan for benefit limits

<table>
<thead>
<tr>
<th>General Expanded Benefits: Available for children and/or adults</th>
</tr>
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<tbody>
<tr>
<td>Behavioral Health Assessment/Evaluation Services&lt;br&gt;Behavioral Health Day Services/Day Treatment&lt;br&gt;Behavioral Health Intensive Outpatient Treatment&lt;br&gt;Behavioral Health Medical Services (e.g., medication management, drug screening, etc.)&lt;br&gt;Behavioral Health Psychosocial Rehabilitation&lt;br&gt;Behavioral Health Screening Services&lt;br&gt;Chiropractic Services&lt;br&gt;Computerized Cognitive Behavioral Therapy&lt;br&gt;Durable Medical Equipment/Supplies&lt;br&gt;Equine Therapy&lt;br&gt;Group Therapy (Behavioral Health)&lt;br&gt;Hearing Services&lt;br&gt;Home Health Nursing/Aide Services&lt;br&gt;Homemaker Services (e.g., hypoallergenic carpet cleanings)&lt;br&gt;Home Visit by a Social Worker&lt;br&gt;Individual/Family Therapy&lt;br&gt;Massage Therapy&lt;br&gt;Medication Assisted Treatment Services&lt;br&gt;Mental Health Targeted Case Management&lt;br&gt;Nutritional Counseling&lt;br&gt;Occupational Therapy&lt;br&gt;Outpatient Hospital Services&lt;br&gt;Pet Therapy&lt;br&gt;Physical Therapy&lt;br&gt;Prenatal Services</td>
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<tr>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Primary Care Services</td>
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<tr>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td>Speech Therapy</td>
</tr>
<tr>
<td>Substance Abuse Treatment or Detoxification Services (Outpatient)</td>
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<td>Therapeutic Behavioral On-Site Services</td>
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<td>Vaccine - Influenza</td>
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<tr>
<td>Vaccine - Pneumonia</td>
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<tr>
<td>Vaccine - Shingles</td>
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<td>Vaccine - TDaP</td>
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<tr>
<td>Vision Services</td>
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<tr>
<td>Waived Copayments</td>
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**Expanded Benefits Continued**

(Services that are covered in addition to your current benefits)

Contact the plan for benefit limits

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<td>Behavioral Health Services for Caregivers (Not Medicaid Enrolled Caregivers)</td>
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<td>Collaborative Care</td>
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<td>Computerized Cognitive Behavioral Therapy for Caregivers (Not Medicaid Enrolled)</td>
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APPENDIX II

Measuring Plans’ Performance

I. Statewide Medicaid Managed Care (SMMC)

SMMC plans are required to collect and report MMA and LTC performance measures, as applicable, and Dental plans are required to collect and report dental performance measures using statewide data to the Agency by July 1 of each year, covering services that their enrollees received in the previous calendar year. The Agency compares plan-specific and aggregate program HEDIS and other performance measure data to national benchmarks, as available, to assess the performance of the SMMC program. The Agency compares plan-specific HEDIS performance measure data to national benchmarks to calculate performance measure liquidated damages and ratings for the Florida Medicaid Health Plan Report Card, which is available online at: http://www.floridahealthfinder.gov. The Agency also posts a full report of Agency performance measures, by MMA and LTC plan, to the Agency’s website: http://ahca.myflorida.com/Medicaid/quality_mc/submission.shtml.

II. Managed Medical Assistance

A. Required Performance Measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool developed and maintained by the National Committee for Quality Assurance (NCQA) that is used by more than 90 percent of America’s health plans to measure performance on important dimensions of health care and service. Widespread use of HEDIS performance measures allows for an “apples-to-apples” comparison of Florida Medicaid health plans’ performance to each other and to plans around the nation.

The Agency requires MMA plans to collect and report annually a specified list of performance measures, certified by a qualified auditor. NCQA licenses organizations and certifies selected employees of licensed organizations to conduct audits using NCQA’s standardized audit methodology. The HEDIS compliance audit indicates whether a plan has adequate and sound capabilities for processing medical, member, and provider information as a foundation for accurate and automated performance measurement. The audit is composed of two parts: an overall information systems capabilities assessment and an evaluation of the plan’s ability to comply with conventional reporting practices and HEDIS specifications for the various HEDIS domains. While many of the performance measures the Agency requires health plans to report are HEDIS measures, the Agency requires that plans have the non-HEDIS measures audited and certified as well.

The Agency requires health plans to contract with software vendors that are certified through NCQA’s Measure Certification program. The Measure Certification program validates the integrity of the software and demonstrates that the performance measures meet current NCQA
standards, which helps ensure the accuracy of reporting measures, and produces more reliable and comparable results.

Over the past four years, the Agency has made several changes to the list of performance measures that the health plans are required to report, due to modifications to HEDIS by the NCQA and due to changes to the Child Core Set and Adult Core Set by Federal CMS. The Agency has sought out standardized national measures as much as possible, but has retained several Agency-defined measures, keeping them as HEDIS-like as possible. Several HEDIS measures have been retired by NCQA and thus have been removed from the Agency’s list of required performance measures (Call Abandonment, Comprehensive Diabetes Care – LDL Control, and Comprehensive Diabetes Care – LDL Screening). Eleven HEDIS measures, nine of which are in the Core Sets, have been adopted by the Agency (including Annual Monitoring for Patients on Persistent Medications, Use of Multiple Concurrent Antipsychotics in Children and Adolescents, and Use of Opioids at High Dosage).
Beginning with the performance measures report for calendar year 2018 services, that was due to the Agency by July 1, 2019, MMA plans are required to report on the following measures.

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
</table>
| **MMA Required Performance Measures**  
**2018-2023 Contract** |  
**HEDIS** |  
**Children’s and/or Adult Core Set Measure** |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)</td>
</tr>
</tbody>
</table>
Yes |  
| 2. Adolescent Well-Care Visits (AWC) |  
Yes |  
| 3. Adults’ Access to Preventive/Ambulatory Health Services (AAP) |  
No |  
| 4. Ambulatory Care (AMB)* |  
Yes |  
| 5. Annual Monitoring for Patients on Persistent Medications (MPM) |  
Yes |  
| 6. Antidepressant Medication Management (AMM) |  
Yes |  
| 7. Adult BMI Assessment (ABA) |  
Yes |  
| 8. Breast Cancer Screening (BCS) |  
Yes |  
| 9. Cervical Cancer Screening (CCS) |  
Yes |  
| 10. Childhood Immunization Status (CIS) – Combinations 2 and 3 |  
Yes |  
| 11. Children and Adolescents’ Access to Primary Care Practitioners (CAP) |  
Yes |  
| 12. Chlamydia Screening in Women (CHL) |  
Yes |  
| 13. Comprehensive Diabetes Care (CDC) |  
• Hemoglobin A1c (HbA1c) testing  
• HbA1c poor control  
• HbA1c good control (<8%)  
• Eye exam (retinal) performed  
• Medical attention for nephropathy |  
Yes |  
| 14. Controlling High Blood Pressure (CBP) |  
Yes |  
| 15. Follow-Up Care for Children Prescribed ADHD Medication (ADD) |  
Yes |  
| 16. Immunizations for Adolescents (IMA) |  
Yes |  
| 17. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) |  
Yes |  
| 18. Lead Screening in Children (LSC) |  
No |  
| 19. Asthma Medication Ratio (AMR) |  
Yes |  
| 20. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) |  
No |  
| 21. Prenatal and Postpartum Care (PPC) |  
Yes |  
| 22. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) |  
Yes |  
| 23. Well-Child Visits in the First 15 Months of Life (W15) |  
Yes |  
| 24. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) |  
Yes |
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<th></th>
<th>HEDIS</th>
<th>Children’s and/or Adult Core Set Measure</th>
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<tr>
<td>25</td>
<td>Follow-Up After Emergency Department Visit for Mental Illness (FUM)</td>
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<td>26</td>
<td>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Treatment (FUA)</td>
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<td>27</td>
<td>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)</td>
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<td>28</td>
<td>Plan All-Cause Readmissions</td>
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<tr>
<td>29</td>
<td>Use of Opioids at High Dosage (UOD)</td>
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<tr>
<td>30</td>
<td>Use of Opioids from Multiple Providers (UOP)</td>
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**Agency-Defined**

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<tr>
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<th>Follow-Up After Hospitalization for Mental Illness (FHM)</th>
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<td>32</td>
<td>Mental Health Readmission Rate (RER)</td>
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**Child Core Set**

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<tr>
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<th>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC)</th>
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<td>34</td>
<td>Contraceptive Care – Postpartum Women Ages 15-20 (CCP-CH)</td>
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<td>35</td>
<td>Elective Delivery (PC-01)</td>
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<td>36</td>
<td>Cesarean Birth</td>
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**Adult Core Set**

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<th>HIV Viral Load Suppression (VLS)</th>
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<td>38</td>
<td>Medical Assistance with Smoking and Tobacco Use Cessation (MSC)</td>
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<td>39</td>
<td>Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD)</td>
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**1. Performance Measure Sanctions**

The Agency may sanction MMA plans for failure to achieve minimum scores on HEDIS performance measures after the first year of poor performance. Each of the performance measures listed below are assigned a point value that correlates to the NCQA HEDIS National Means and Percentiles for Medicaid plans. The scores are assigned according to the table below. Individual performance measures are grouped and scores are averaged within each performance measure group.

<table>
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<tr>
<th>PM Ranking</th>
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<td>&gt;= 90th percentile</td>
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<tr>
<td>75th – 89th percentile</td>
<td>5</td>
</tr>
<tr>
<td>60th – 74th percentile</td>
<td>4</td>
</tr>
<tr>
<td>50th – 59th percentile</td>
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<tr>
<td>25th – 49th percentile</td>
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<td>10th – 24th percentile</td>
<td>1</td>
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<tr>
<td>&lt; 10th percentile</td>
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</table>
MMA plans may receive a monetary sanction of up to $10,000 for each performance measure group where the group score is below three (3). Performance measure groups are as follows:

a. Mental Health and Substance Abuse
   - Antidepressant Medication Management – Effective Acute Phase Treatment
   - Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase
   - Follow-up after Hospitalization for Mental Illness – 7 day
   - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total
   - Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence – 7 day – Total

b. Well-Child
   - Adolescent Well Care Visits
   - Childhood Immunization Status – Combination 3
   - Immunizations for Adolescents – Combination 1
   - Well-Child Visits in the First 15 Months of Life – 6 or more visits
   - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
   - Lead Screening in Children

c. Other Preventive Care
   - Adults’ Access to Preventive/Ambulatory Health Services – Total
   - Adult BMI Assessment
   - Breast Cancer Screening
   - Cervical Cancer Screening
   - Children and Adolescents’ Access to Primary Care – 12-19 years
   - Chlamydia Screening for Women – Total

d. Prenatal/Perinatal
   - Prenatal and Postpartum Care (includes two measures)

e. Diabetes – Comprehensive Diabetes Care measure components
   - HbA1c Testing
   - HbA1c Control (< 8%)
   - Eye Exam
   - Medical Attention for Nephropathy

f. Other Chronic and Acute Care
   - Controlling High Blood Pressure
   - Asthma Medication Ratio – 75% Compliance – Total
   - Annual Monitoring for Patients on Persistent Medications – Total
The Agency will review the Specialty plan’s performance on Specialty plan-specific measure data to determine acceptable performance levels and may establish sanctions for these measures based on those levels after the first year of reporting.

In addition to sanctions, the Agency may require MMA plans to complete a Performance Measure Action Plan (PMAP) after the first year of poor performance.

2. Performance Measure Liquidated Damages

Similar to sanctions, the Agency may impose liquidate damages on plans for failure to achieve minimum scores on HEDIS performance measures.

The Agency compares the MMA plan’s performance measure rates to the NCQA HEDIS National Means and Percentiles for Medicaid plans. Beginning with the performance measures report that is due to the Agency by July 1, 2019, the Agency will use the following methodology when calculating performance measure liquidated damages.

For each eligible HEDIS measure where the MMA plan’s rate falls below the 50th percentile, the MMA plan may receive liquidated damages. Liquidated damages are calculated based on the number of members eligible for the measure who did not receive the service being measured up to the 50th percentile rate. For measures calculated using a sample, liquidated damages will be calculated based on the number of eligible members who did not receive the service being measured, not just those in the sample, up to the 50th percentile rate.

Performance measure liquidated damage amounts per eligible member vary by performance measure tier:

- **Tier 1**: $150 per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.

- **Tier 2**: $100 per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.

- **Tier 3**: $80 per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.

The Agency may reduce the liquidated damage amount per eligible enrollee when a plan’s rate for a performance measure has improved three percentage points or more compared to the previous reporting period and that rate is between the 40th and 50th percentiles.

Liquidated damages are not imposed for measures being reported by plans for the first time or for measures for which NCQA has not calculated means and percentiles. For measures with multiple components, liquidated damages are often assessed for one component (e.g., Antidepressant Medication Management has two components, an acute phase and a continuation phase, but liquidated damages are only assessed for the acute phase component).

Due to calendar year 2018 being a transition year across contracts, the Agency will collect and may report performance measures publicly, labeling such performance measures as
“transition year” measures. The Agency will not assess liquidated damages or sanctions related to where performance measure results fall relative to the NCQA HEDIS National Means and Percentiles for Medicaid plans, but shall assess liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting.

The Agency may assess liquidated damages for each of the following measures:

- **Tier 1:**
  1. Antidepressant Medication Management – Effective Acute Phase Treatment
  2. Adherence to Antipsychotic Medications for Individuals with Schizophrenia
  3. Comprehensive Diabetes Care – HbA1c Control (<8%)
  4. Controlling High Blood Pressure
  5. Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence – 7 day – Total
  6. Follow-up after Emergency Department Visit for Mental Illness – 7 day
  7. HIV Viral Load Suppression
  8. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total
  9. Medication Management for People with Asthma – 75% Compliance – Total

- **Tier 2:**
  1. Adolescent Well-Care Visits
  2. Adults’ Access to Preventive/Ambulatory Health Services – Total
  3. Childhood Immunization Status – Combination 3
  4. Children and Adolescents’ Access to Primary Care Practitioners – includes 4 age group rates
  5. Immunizations for Adolescents – Combination 1
  6. Timeliness of Prenatal Care
  7. Well-Child Visits in the First 15 Months of Life – 6 or more visits
  8. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

- **Tier 3:**
  1. Adult BMI Assessment
  2. Annual Monitoring for Patients on Persistent Medications – Total
  3. Breast Cancer Screening
  4. Cervical Cancer Screening
  5. Chlamydia Screening in Women – Total
  6. Comprehensive Diabetes Care – HbA1c Testing
(7) Comprehensive Diabetes Care – Eye Exam
(8) Comprehensive Diabetes Care – Medical Attention for Nephropathy
(9) Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase
(10) Lead Screening in Children
(11) Postpartum Care
(12) Well-Child Visits in the First 15 Months of Life – 0 visits

B. Medicaid Health Plan Report Card

The Special Terms and Conditions of the MMA program 1115 waiver require that Florida create a health plan report card that must be posted on the State’s website and present an easily understandable summary of quality, access, and timeliness of care based on performance data for each MMA plan. Recipients can use this information to compare plans and help them to decide which plan to choose.

Individual performance measures are used to compare plans and are rolled up into six performance measure categories:

- Pregnancy-related Care
- Keeping Kids Healthy
- Children’s Dental Care
- Keeping Adults Healthy
- Living With Illness
- Behavioral Health Care

Plans are compared against national Medicaid benchmarks published by NCQA, using a 5-star rating scale. Only those who have been enrolled in plans for a specified amount of time are included in measure calculations.

The report card displays ratings by plan for each of the six performance measure categories. There are also options to see the plans’ 1–5 star ratings per individual performance measure in the categories, and to see the plans’ actual scores for each measure (e.g., the percentage of plan enrollees who received breast cancer screening).

The Agency has published four Report Cards. The currently posted Medicaid Health Plan Report Card, published in November 2018, is based on HEDIS 2018 data (i.e., CY 2017 data reported in 2018) and includes plan performance data for services provided under the MMA plan contracts.

The Agency will continue to make improvements to the report card to make it more useful to consumers.

C. Achieved Savings Rebate

In order to ensure that capitated payments made to plans participating in the SMMC program are appropriate, the Agency has implemented a statutorily defined program called the Achieved
Savings Rebate program. This program includes enhanced financial monitoring of plans and plan expenditures through submission of detailed financial reporting by plans and an annual audit of that documentation conducted by an independent certified public accountant in accordance with generally accepted auditing standards.

Audits must include an annual premium revenue, medical and administrative costs, and income or losses reported by each prepaid plan, in order to determine and validate the achieved savings rebate. Plans are required to make available to the Agency and the Agency’s contracted certified public accountant all books, accounts, documents, files, and information that relate to the prepaid plan’s Medicaid transactions.

The independent auditor will determine the achieved savings of each plan. Plans who have achieved savings are also eligible to retain an additional 1% of revenue by meeting or exceeding certain quality standards. In order to retain the 1% incentive, plans must achieve performance measure rates at or above the 75th percentile for five of the ten performance measures listed below, with none of the rates below the 50th percentile. The performance measures are as follows:

a. Antidepressant Medication Management – Effective Acute Phase Treatment
b. Adherence to Antipsychotic Medications for Individuals with Schizophrenia
c. Comprehensive Diabetes Care – HbA1c Control (<8%)
d. Controlling High Blood Pressure
e. Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence – 7 day – Total
f. Follow-up after Emergency Department Visit for Mental Illness – 7 day
g. Follow-up after Hospitalization for Mental Illness – 7 day
h. HIV Viral Load Suppression
i. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation – Total
j. Medication Management for People with Asthma – 75% Compliance – Total

D. Well-Child Visit Performance Measures

The Federal CMS-416 report, which reports on children’s utilization of services, is due to Federal CMS on April 1 of each year. To increase the accuracy of the report and avoid duplication, the Agency worked with Federal CMS to refine the Agency’s data collection process to eliminate potential duplication of eligible recipients in the reported data by comparing FFS claims and encounter data. Each spring, the Agency calculates statewide CMS-416 results based on claims and encounter data. The Agency also requires MMA plans to collect and report their plan-specific CMS-416 and well-child visit screening results by July 1 of each year, representing services received during the previous federal fiscal year.

MMA plans, by Agency contract and state law, must achieve a well-child visit rate of at least 80% for those members who are continuously enrolled in the plan for at least eight
months during the federal fiscal year (October 1 – September 30). The well-child visit rate indicates the percentage of children that receive the number of initial and periodic screening services required by Florida’s periodicity schedule, and is based on the data reported by the MMA plan in its audited Well-Child Visit (CMS-416) and FL 80% Screening Report that is due annually to the Agency. For each federal fiscal year that the plan does not achieve the 80% well-child visit rate, the Agency may require a corrective action plan (CAP) to be submitted and may assess liquidated damages.

In addition, the Agency contract and Centers for Medicare & Medicaid Services require that plans must achieve at least an 80% well-child visit participation rate. The well-child visit participation rate indicates the percentage of children that receive any initial and periodic screening service during the federal fiscal year and will be based on the data reported by the MMA plan in its audited Well-Child Visit (CMS-416) and FL 80% Screening Report that is due annually to the Agency. For each federal fiscal year that the plan does not meet the 80% well-child visit participation rate, the Agency may require a CAP to be submitted and may assess liquidated damages.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

CAHPS surveys ask enrollees to report on and evaluate their experiences with health care and their health plan. CAHPS surveys are developed and maintained by the Agency for Healthcare Research and Quality. These surveys are confidential, standardized, cover topics that are important to consumers, and focus on aspects of quality that consumers are best qualified to assess, such as customer service and ease of access to health care services.

MMA plans are contractually required to contract with a NCQA-certified CAHPS Survey Vendor to conduct the CAHPS Health Plan Survey each year. The surveys must be conducted according to NCQA’s mixed mode protocol (mail with telephone follow-up) and plans must field an adult survey (for enrollees 18 years of age and older) and a child survey (for parents to report on the experience of a child 17 years of age or younger). In order to ensure that the CAHPS surveys reflect the experience of a diverse population, all surveys must be available in English and Spanish. The survey vendors are required to pull a systematic sample of enrollees to whom the surveys will be mailed, which only includes those enrollees who have been continuously enrolled in the plan for six months prior to the start of the survey. In 2019, the required Adult Medicaid sample size was 1,350 and the Child Medicaid sample size was 1,650.

Plans are required to report their certified results to the Agency on an annual basis. Beginning with the 2016 survey, plans were also required to report their results to NCQA so they may be included in the National Medicaid Means and Percentiles. The results of these surveys are posted on the Agency’s Florida Health Finder website so that Medicaid enrollees may use the survey results to compare plans when making enrollment decisions.
III. Long-term Care

A. Required Performance Measures

The 2018-2023 SMMC contract requires the plans providing long-term care (LTC) services to report on the measures in the table below. Plans who operated under the prior SMMC contracts were required to collect and report on the first four measures by November 1, 2019, for services provided in calendar year 2018. Plans who were not providing LTC services under the prior SMMC contracts are required to collect and report on the following measures by July 1, 2020 for services provided in calendar year 2019.

<table>
<thead>
<tr>
<th>Centers for Medicare and Medicaid Services and Mathematica Managed Long-Term Services and Supports (MLTSS) Measures</th>
<th>2018-2023 Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Comprehensive LTSS Assessment and Update</td>
<td></td>
</tr>
<tr>
<td>2 Comprehensive LTSS Care Plan</td>
<td></td>
</tr>
<tr>
<td>3 Shared Care Plan</td>
<td></td>
</tr>
<tr>
<td>4 Reassessment and Care Plan Update after Discharge</td>
<td></td>
</tr>
<tr>
<td>5 Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls</td>
<td></td>
</tr>
<tr>
<td>6 Admission to an Institution from the Community Among LTSS Beneficiaries</td>
<td></td>
</tr>
<tr>
<td>7 Successful Transition after Short-Term Institutional Stay Among LTSS Enrollees</td>
<td></td>
</tr>
<tr>
<td>8 Successful Transition after Long-Term Institutional Stay Among LTSS Enrollees</td>
<td></td>
</tr>
</tbody>
</table>

1. Performance Measure Sanctions

The Agency may sanction LTC plans for failure to achieve minimum scores on the below performance measures specified by the Agency after the first year of poor performance.

<table>
<thead>
<tr>
<th>Centers for Medicare and Medicaid Services and Mathematica MLTSS Measures</th>
<th>Rate and applicable sanction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive LTSS Assessment and Update</td>
<td>Rate &lt; 85%, $10,000 monetary sanction</td>
</tr>
<tr>
<td>Comprehensive LTSS Care Plan</td>
<td>Rate &lt; 85%, $10,000 monetary sanction</td>
</tr>
<tr>
<td>Shared Care Plan</td>
<td>Rate &lt; 85%, $10,000 monetary sanction</td>
</tr>
<tr>
<td>Reassessment and Care Plan Update after Discharge</td>
<td>Rate &lt; 85%, $10,000 monetary sanction</td>
</tr>
</tbody>
</table>

LTC plans may receive a monetary sanction for measures for which their scores do not meet the thresholds given in Table 2 for the first offense. LTC plans shall receive a monetary sanction for measures for which their scores do not meet the thresholds given in the above table for the second offense and subsequent offenses.
2. Performance Measure Liquidated Damages

The Agency compares the LTC plans’ performance measure rates to the established thresholds. The liquidated damages thresholds and amounts are outlined in Table 3.

<table>
<thead>
<tr>
<th>Table 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LTC Performance Measure Liquidated Damages Amounts</strong></td>
</tr>
<tr>
<td>Comprehensive LTSS Assessment and Update</td>
</tr>
<tr>
<td>Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of $100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.</td>
</tr>
<tr>
<td>Comprehensive LTSS Care Plan</td>
</tr>
<tr>
<td>Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of $100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.</td>
</tr>
<tr>
<td>Shared Care Plan</td>
</tr>
<tr>
<td>Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of $100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.</td>
</tr>
<tr>
<td>Reassessment and Care Plan Update after Discharge</td>
</tr>
<tr>
<td>Failure to achieve a rate of 85% or higher for this measure will result in liquidated damages of $100 per each case in the denominator not present in the numerator for the measure up to the 85% rate.</td>
</tr>
</tbody>
</table>

Due to calendar year 2018 being a transition year across contracts, the Agency will collect and may report performance measures publicly, labeling such performance measures as “transition year” measures. The Agency will not assess liquidated damages or sanctions related to where performance measure results fall relative to established targets, but shall assess liquidated damages and sanctions due to incomplete, late, and/or inaccurate reporting.

During negotiations, LTC plans agreed to achieve at least a 2% improvement in their performance measure rates each year of the Contract until the LTC plan achieves the performance standards established by the Agency. One plan committed to at least a 5% improvement each year. If LTC plans fail to comply with these commitments, they may receive liquidated damages as determined by the Agency.

B. Achieved Savings Rebate

In order to be eligible to retain up to an additional 1% of revenue in the first year, LTC plans must exceed a specified threshold for each of the performance measures listed below:

- Comprehensive LTSS Assessment and Update
- Comprehensive LTSS Care Plan
- Shared Care Plan
C. LTC - Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys

The LTC plans are required to conduct an annual enrollee satisfaction survey using the Home and Community-Based Services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey and following the Technical Assistance Guide created by the Centers for Medicare & Medicaid Services (CMS). This confidential survey assesses experience with care for LTC enrollees receiving home and community-based services. The first HCBS CAHPS survey was fielded in spring 2018. The 2019 HCBS CAHPS survey results were due to the Agency by November 1, 2019. Subsequent submissions are due to the Agency by September 1st of every year.

LTC plans are required to contract with an NCQA-certified CAHPS Survey Vendor to conduct the surveys with a minimum sample size of 2000 and a target of 411 completed surveys. The survey must be administered telephonically or in person. LTC plans are required to use the core HCBS CAHPS 1.0 Survey. If they would like to add questions to the survey, those questions may be added to the end of the core survey. Additional questions must be submitted to the Agency for review and approval prior to being included in the survey.

To be included in the survey sample, enrollees must have been enrolled in the plan and receiving home and community-based services for at least three consecutive months. Enrollees can have someone help them fill out the survey if needed.

IV. Dental Health Plans

A. Required Performance Measures

Beginning with the performance measures report that is due to the Agency by July 1, 2020, Dental plans shall collect and report on the following measures.

| Table 5 |
| Dental Plan Required Performance Measures |
| 2018-2023 Contract |
| HEDIS |
| 1 | Annual Dental Visit |
| | Child Core Set |
| 2 | Preventive Dental Services |
| 3 | Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk |
| | Dental Quality Alliance |
| 4 | Oral Evaluation |
| 5 | Topical Fluoride for Children at Elevated Caries Risk |
| 6 | Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children |
| 7 | Follow-up after Emergency Department Visits for Dental Caries in Children |
1. Performance Measure Sanctions

The Agency may sanction Dental Health Plans for failure to maintain and/or improve scores on performance measures after the first year of poor performance. The Agency may impose monetary sanctions as described below in the event that the plan’s performance is not consistent with the Agency’s expected standards.

For each of the performance measures listed below where the Dental Health Plan’s rate decreases more than two percentage points compared to the previous year, the plan may receive a monetary sanction of $10,000.

- Annual Dental Visit
- Preventive Dental Services
- Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk
- Dental Treatment Services
- Oral Evaluation
- Topical Fluoride for Children at Elevated Caries Risk
- Follow-up after Emergency Department Visits for Dental Caries in Children

2. Performance Measure Liquidated Damages

The Agency compares the dental plans’ performance measure rates to the targets that each plan committed to for each contract year. If a dental plan does not meet its target for preventive dental services or dental treatment services, the liquidated damage amount is $50,000 per occurrence in addition to $10,000 for each percentage point less than the target. If a dental plan does not meet its target for the Annual Dental Visit measure, the liquidated damage amount is $25 per eligible enrollee not receiving the service up to the 50th percentile rate. Two additional performance measure liquidated damages are in the table below.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children (ages 0 - &lt;21 years)</td>
<td>$250 per occurrence</td>
</tr>
<tr>
<td>Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Adults (ages 21 years and up)</td>
<td>$100 per occurrence</td>
</tr>
</tbody>
</table>
A. Achieved Savings Rebate

Dental Health Plans must achieve the below established target rates for a select list of dental performance measures in order to be eligible to retain up to an additional 1% of revenue.

- **Federal Fiscal Year (FFY) 2018-19/Calendar Year (CY) 2019:**
  - Annual Dental Visit: 60% or higher
  - Preventive Dental Services: 50% or higher

- **FFY 2019-20/CY 2020:**
  - Annual Dental Visit: 60% or higher
  - Preventive Dental Services: 50% or higher

- **FFY 2020-21/CY 2021:**
  - Annual Dental Visit: 62% or higher
  - Preventive Dental Services: 52% or higher

- **FFY 2021-22/CY 2022:**
  - Annual Dental Visit: 63% or higher
  - Preventive Dental Services: 54% or higher

- **FFY 2022-23/CY 2023:**
  - Annual Dental Visit: 65% or higher
  - Preventive Dental Services: 56% or higher

B. Well-Child Visit Performance Measures

Each dental plan committed to achieving particular targets for preventive dental services and dental treatment services in each contract year. Failure to meet or exceed the targets may result in a corrective action plan (CAP) in addition to liquidated damages.
APPENDIX III
Managed Care Contract Provisions

A. External Quality Review Requirements

The state’s MCO and PAHP contracts require the entities to be subject to annual, external independent review of the quality outcomes, timeliness of, and access to the services covered under each contract.

The Agency’s contracted External Quality Review Organization produces an Annual Technical Report that reports on its review activities.

The reference to the contract provisions incorporating this requirement can be found in Table 1.

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>External Quality Review</strong></td>
</tr>
<tr>
<td>42 CFR 438.350</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>Managed Medical Assistance (MMA) and Long Term care (LTC) Programs</td>
<td>Attachment II, Section IX. A. 1 and 3</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section IX. A. 1 and 5</td>
</tr>
</tbody>
</table>

B. Access standards

1. Availability of Services

The state’s MCO and PAHP contracts require the entities to comply with all applicable federal and state laws, rules, and regulations. Including but not limited to: all access to care standards in Title 42 Code of Federal Regulations (CFR) chapter IV, subchapter C; Title 45 CFR 95, General Grants Administration Requirements; chapter 409 and as applicable part I and III of chapter 641, Florida Statutes, regarding managed care. MCO and PAHP access to care requirements are in this section. The table following each standard provides the location where this requirement is in each of the state’s MCO and PAHP contracts.

(a) Maintains and Monitors a Network of Appropriate Providers

The state’s MCO and PAHP contracts require each entity to establish and maintain a network of appropriate providers sufficient to provide adequate access to all services covered under each entity’s contract for the enrolled population in accordance with section 1932(b)(7) of the Social Security Act (as enacted by section 4704(a) of the Balanced Budget Act of 1997). The entities are required to make available and accessible facilities, service locations, service sites, and personnel sufficient to provide the covered services. The entities are required to provide
adequate assurances, with respect to a service area, and demonstrate the capacity to serve the 
expected enrollment in such service area. Including assurances that the entity: offers an 
appropriate range of services; offers access to preventive and primary care services for the 
populations expected to be enrolled in such service area; and maintains a sufficient number, 
mix, and geographic distribution of providers of services. Written agreements must support 
each entity’s network of appropriate providers.

The state requires the MCOs and PAHPs to submit provider network information to enable the 
state to monitor each plan’s compliance with required provider network composition and primary 
care provider to member ratios, and for other uses, the state deems pertinent. The state also 
reviews and approves plan provider networks to ensure each plan establishes and maintains a 
network of appropriate providers that is in compliance with 42 CFR 438.206(b)(1) and chapters 
409 and 641, F.S. The state conducts the initial provider network review prior to the plan 
becoming operational and annually thereafter to ensure compliance with all applicable federal 
and state regulations.

The state requires the MCOs and PAHPs to furnish services up to the limits specified by the 
Florida Medicaid program. The plans are responsible for contracting with providers who meet 
all provider and service and product standards specified in the state’s Medicaid services 
handbooks and fee schedules and the plans’ provider handbooks, which must be incorporated 
in all plan subcontracts by reference, for each service category covered by the plan. Exceptions 
exist where different standards are specified elsewhere in the contract or if the standard is 
waived in writing by the state on a case-by-case basis when the member's medical needs would 
be equally or better served in an alternative care setting or using alternative therapies or 
deVICES within the prevailing medical community.

The state requires MCOs and PAHPs to make emergency medical care available 24 hours a 
day, seven days a week. The entities are required to assure that primary care physician 
services and referrals to specialty physicians are available on a timely basis, to comply with the 
following standards: urgent care - within one day; routine sick patient care - within one week;
and well care - within one month. The plans are required to have telephone call policies and 
procedures that shall include requirements for call response times, maximum hold times, and 
maximum abandonment rates. The primary care physicians and hospital services provided by 
the plans are available within 30 minutes typical travel time, and specialty physicians and 
ancillary services must be within 60 minutes typical travel time from the member’s residence. 
For rural areas, if the plan is unable to contract with specialty or ancillary providers who are 
within the typical travel time requirements, the state may waive, in writing, these requirements.

The plans are required to allow each enrollee to choose his or her health care 
professional, to the extent possible and appropriate. Each plan is required to provide 
the state with documentation of compliance with access requirements no less 
frequently than the following: (a) at the time, it enters into a contract with the state and 
(b) at any time, there has been a significant change in the plan's operations that would 
affect adequate capacity and services. Including but not limited to: (1) changes in plan 
services, benefits, geographic service area, or payments; and (2) enrollment of a new 
population in the plan.

The reference to the contract provisions incorporating these requirements can be found in 
Table 2.
(b) Provides female enrollees with direct access to a women’s health specialist.

The state requires MCOs and PAHPs to provide female enrollees direct access to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive care services, which is in addition to the enrollee’s designated source of primary care if that source is not a woman’s health specialist. The state requires the entities to offer each member a choice of primary care physicians, which includes women’s health specialists.

The reference to the contract provision incorporating this requirement can be found in Table 3.

### Table 3

**Direct Access to Women’s Health Specialist**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Exhibit II-A, Section VIII. A.4.a.(2)</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Exhibit II-A, Section VIII. A.4.a.(2)</td>
</tr>
</tbody>
</table>
(c) Second Opinion from a Qualified Health Care Professional.

The state requires each MCO and PAHP to have a procedure for enrollees to obtain a second medical opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain a second opinion outside the network, and requires the plan to be responsible for payment of such services. The plans are required to clearly state the procedure for obtaining a second medical opinion in the member handbook. In addition, the plan’s second opinion procedure is required to be in compliance with section 641.51, F.S., and 42 CFR 438.206(3)(b).

The reference to the contract provision incorporating this requirement can be found in Table 4.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Programs</td>
<td>Attachment II, Section VI. G.2.c.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. H.2.d.</td>
</tr>
</tbody>
</table>

(d) Provision of Out of Network Medically Necessary Services.

The state requires MCOs or PAHPs that are unable to provide medically necessary services covered under the contract to a particular enrollee to adequately and timely cover these services outside of the network for the enrollee for as long as the MCO or PAHP is unable to provide them in compliance with 42 CFR 438.206(b)(4).

The reference to the contract provision incorporating this requirement can be found in Table 5.


<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Organizations</td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Programs</td>
<td>Attachment II, Section VIII. A.1.d.(1) and (2)</td>
</tr>
<tr>
<td>Prepaid Ambulatory Health Plans</td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VIII. A.1.d. (1) and (2)</td>
</tr>
</tbody>
</table>

(e) Coordination with Out of Network Providers with Respect to Payment.

The state requires the plans to coordinate with out-of-network providers with respect to payment and to ensure that cost to the enrollee is no greater than it would be if the covered services were furnished within the network.

The reference to the contract provision incorporating this requirement can be found in Table 6.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Organizations</td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Programs</td>
<td>Attachment II, Section VIII. A.1.i.</td>
</tr>
<tr>
<td>Prepaid Ambulatory Health Plans</td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VIII. A.1.i.</td>
</tr>
</tbody>
</table>
(f) Demonstration of Providers’ Credentialing.

The state requires the MCOs and PAHPs to establish and verify credentialing and recredentialing criteria for all professional providers and that, at a minimum, the plan providers meet the state's Medicaid participation standards. Pursuant to 641.512(1)(a) F.S., the managed care plans must be accredited by a nationally recognized accrediting body, or have initiated the accreditation process within one (1) year after contract execution. If a managed care plan is not accredited within eighteen (18) months after contract execution, the Agency may terminate the contract and will suspend all assignments until a nationally recognized body accredits the managed care plan. The following are some of the provisions in chapter 641, Florida Statutes, related to licensed capitated plan’s provider credentialing:

1) Section 641.495 (5), Florida Statutes, provides that the plan shall exercise reasonable care in assuring that delivered health care services are performed by appropriately licensed providers.

2) Section 641.495 (6), Florida Statutes, provides that the plan shall have a system for verification and examination of the credentials of each of its providers. The organization shall maintain in a central file the credentials, including a copy of the current Florida license, of each of its physicians.

3) Section 641.51(2), Florida Statutes, provides that the plan shall have an ongoing internal quality assurance program for its health care services. The program shall include, but not be limited to, the following:

   a) A written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;

   b) A written statement describing how state-of-the-art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;

   c) Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided; and (d) A written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the organization.

Prior to contracting, the state reviewed the MCOs’ and PAHPs’ written policies and procedures for credentialing of providers to ensure compliance with all applicable federal and state regulations.

The reference to the contract provision incorporating this requirement can be found in Table 7.
Table 7
Provider Credentialing
42 CFR 438.206(b)(6)

<table>
<thead>
<tr>
<th>Plan Type</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Programs</td>
<td>Attachment II, Section VIII. C. 1 and 2; Section IX. A. 2.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VIII. C. 1 and 2; Section IX. A. 4.</td>
</tr>
</tbody>
</table>

(g) Timely Access to Care.

The state requires the MCOs and PAHPs to:

1. Meet the state’s timely access to care and services, taking into account the urgency of the need for services;
2. Ensure that the network of providers offers hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service. If the provider serves only Medicaid enrollees;
3. Make services included in the contract available 24 hours a day, seven days a week, when medically necessary;
4. Establish mechanisms to ensure compliance by providers;
5. Monitor providers regularly to determine compliance; and
6. Take corrective action if there is a failure to comply.

Prior to contracting with an MCO or PAHP, the state assures the plan’s ability to comply with federal and state timely access requirements. The state conducts annual reviews of the plans to ensure on-going compliance with the timely access requirements of chapter 409 and 641, F.S., and 42 CFR 438.206(c).

The MCOs and PAHPs are required to ensure that appropriate services are available as follows:

1. Emergency – immediately upon presentation or notification; in addition the plans are required to maintain sufficient medical staff available 24 hours per day to handle emergency care inquiries;
2. Urgent Care – within one day;
3. Routine Sick Patient Care – within one week;
4. Well Care – within one month;
5. Pregnancy Related Care – Within 30 calendar days of enrollment, the plans are required to advise members of and ensure the availability of, a screening for all members known to be pregnant or who advise the plan that they may be pregnant. The plan shall refer pregnant members and members reporting they may be pregnant for appropriate prenatal care; and
6. **Health Risk Assessment** – the plans are required to contact each new member at least two times, if necessary, within 90 calendar days of enrollment, to urge scheduling of an initial appointment with the primary care provider for the purpose of a health risk assessment.

The reference to the contract provisions incorporating these requirements can be found in Table 8.

| **Table 8**  
| **Timely Access to Care**  
| **42 CFR 438.206(c)(1)**  
| **Plan Type** | **Contract Provision**  
| **Managed Care Organizations**  
| MMA and LTC Programs | Attachment II, Section VIII, A.4.  
| **Prepaid Ambulatory Health Plans**  
| Dental Program | Attachment II, Section VIII, A.7.  

(h) **Cultural Considerations.**

The state requires the MCOs and PAHPs to participate in Florida’s efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The plans are required to assure that appropriate foreign language versions of all materials are developed and available to members and potential members. For enrollees whose primary language is a foreign language, the plans are required to provide interpreter services in person where practical or by telephone. Foreign language versions of materials are required if, as provided annually by the state, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

The state requires the plans to ensure that all marketing, pre-enrollment, member, disenrollment, and grievance materials developed for the Medicaid population adhere to the following policies and procedures.

The plan shall assure that appropriate foreign language versions of all materials are developed and available to members and potential members.

All materials developed for the Medicaid population must be at or near the fourth-grade comprehension level so that the materials are understandable (in accordance with section 1932(a)(5) of the Social Security Act as enacted by section 4701 of the Balanced Budget Act of 1997). Materials must be available in alternative communication methods (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities.

The reference to the contract provision incorporating this requirement can be found in Table 9.
Table 9
Cultural Considerations
42 CFR 438.206(c)(2)

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section IV, G; Section V, B.2 and C. 2.</td>
</tr>
</tbody>
</table>

| **Prepaid Ambulatory Health Plans** |                                                                                   |

2. Assurances of Adequate Capacity and Services

(a) Offers an Appropriate Range of Preventive, Primary Care, and Specialty Service.

Prior to contracting with the state, the MCOs and PAHPs are required to submit documentation that demonstrates the plan: (1) offers an appropriate range of preventive, primary care, and specialty services and (2) maintains a network of appropriate providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The plans are required to submit provider network information used by the state to monitor the plan’s compliance with required provider network composition and primary care provider to enrollee ratios and for other uses deemed pertinent.

The reference to the contract provision incorporating this requirement can be found in Table 10.

Table 10
Documentation of Adequate Capacity & Services
42 CFR 438.207(b)

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VIII. A.</td>
</tr>
</tbody>
</table>

| **Prepaid Ambulatory Health Plans** |                                                                                   |
| Dental Program            | Attachment II, Section VIII. A.                                                   |

(b) Maintains a Network of Providers that is Sufficient in Number, Mix, and Geographic Distribution.

The state requires the MCOs and PAHPs to provide the state documentation of compliance with access requirements specified in 42 CFR 438.207(c) that are no less frequent than the following:
1) At the time, it enters into a contract with the Agency for Health Care Administration.

2) At any time there has been a significant change in the plan’s operations that would affect adequate capacity and services, including but not limited to:
   a) Changes in plan services, benefits, geographic service area, or payments.
   b) Enrollment of a new population in the plan.

At least sixty (60) days before the termination effective date, the plan must provide written notification to all enrollees. The notification must include the following information: the date on which the managed care plan will no longer participate in the state’s Medicaid program and instructions on contacting the Agency’s enrollment broker help line to obtain information on enrollment options and to request a change in managed care plans.

The state conducts at least annual reviews of the plan’s network of providers to ensure compliance with federal and state access to care standards.

The reference to the contract provision incorporating this requirement can be found in Table 11.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VIII. B.3 and C.7.c; Section XV. G.4.h.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VIII. B.3 and C.7.c; Section XV. G.4.g.</td>
</tr>
</tbody>
</table>

3. Coordination and Continuity of Care

(a) Ongoing Source of Primary Care

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PAHPs to implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and whom the plan has formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. The MCOs and PAHPs are required to offer each enrollee a choice of primary care physicians. After making a choice, each member shall have a single or group primary care physician. The plan shall inform enrollee of the following: (1) their primary care physician assignment, (2) their ability to choose a different primary care provider, (3) a list of providers from which to make a choice, and (4) the procedures for making a change.
The reference to the contract provision incorporating this requirement can be found in Table 12.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Exhibit II-A, VI. D.1, 2, 3, and 4.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. E.</td>
</tr>
</tbody>
</table>

(b) Coordination of All Services that the Enrollee Receives.

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PAHPs to implement procedures to coordinate the services the plan furnishes to the enrollee with the services the enrollee receives from any other managed care entity during the same period of enrollment.

The reference to the contract provision incorporating this requirement can be found in Table 13.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VI, E; Exhibit II-A, Section VI, E.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. F.</td>
</tr>
</tbody>
</table>

(c) Sharing of Identification and Assessment Information to Prevent Duplication of Services for Individuals with Special Health Care Needs.

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PAHPs to implement procedures to share with other managed care entities serving the enrollee with special health care needs the results of its identification and assessment of the enrollee’s needs to prevent duplication of those activities.
The reference to the contract provision incorporating this requirement can be found in Table 14.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VI. E.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. F.4.</td>
</tr>
</tbody>
</table>

(d) Protection of Enrollee’s Privacy in the Process of Coordinating Care.

Pursuant to 42 CFR 428.208(b)(6), the state requires the plans to implement procedures to ensure that in the process of coordinating care, each enrollee’s privacy is protected in accordance with the privacy requirements in 45 CFR Part 160 and 164 Subparts A and E, to the extent that they are applicable. The state requires, through its contracts, that for medical records and any other health and enrollment information that identifies a particular enrollee, uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

The reference to the contract provisions incorporating this requirement can be found in Table 15.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VIII. C.5.c.(25); Section X, D.1.d.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VIII. C.5.c.(23); Section X, D.1.d.</td>
</tr>
</tbody>
</table>

(e) Additional services for persons with special health care needs, including Identification, Assessment, Treatment Plans, and Direct Access to Specialists.
The state requires the MCOs and PAHPs to implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms include evaluation of health risk assessments, claims data, and, if available, CPT/ICD-10 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. The treatment plan for an enrollee must be developed by the enrollee’s primary care provider with enrollee participation; in consultation with any specialists caring for the enrollee; approved by the plan in a timely manner if this approval is required; and developed in accordance with any applicable state quality assurance and utilization review standards. For enrollees with special health care needs, each plan must have a mechanism in place to allow enrollees to access a specialist (i.e. through a standing referral or an approved number of visits) directly as appropriate for the enrollee’s condition and identified needs.

The reference to the contract provision incorporating this requirement can be found in Table 16.

<table>
<thead>
<tr>
<th>Plan Type</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VI. E. 1 and 5.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. F. 2 and 4.</td>
</tr>
</tbody>
</table>

4. Coverage and authorization of services

(a) The amount, duration and scope of each service that Florida MCOs and PAHPs are required to offer.

The state requires the MCOs and PAHPs to comply with all the provisions of the contract and its amendments, if any, and to act in good faith in the performance of the contract provisions. The plans are required to develop and maintain written policies and procedures to implement the provisions of this contract. The plans are required to agree by contract that failure to comply with these provisions may result in the assessment of penalties and/or termination of the contract in whole or in part, as set forth in the contract. The plans are required to comply with all pertinent state rules in effect throughout the duration of the contract.

The state requires the MCOs and PAHPs to comply with all current state handbooks noticed in or incorporated by reference in rules relating to the provision of services set forth in the contract. The plans are required to comply with the limitations and exclusions in the state coverage policies unless otherwise specified by the contract. In no instance may the limitations or exclusions imposed by the plan be more stringent than those specified in the coverage
policies. Pursuant to 42 CFR 438.210(a), the plan must furnish services up to the limits specified by the Medicaid program. The plan may exceed these limits. Service limitations shall not be more restrictive than the Florida fee-for-service program, pursuant to 42 CFR 438.210(a), except as approved by the state and authorized in Florida’s 1115 Medicaid waiver or other applicable waivers.

The state allows the plans to offer services to enrolled Medicaid recipients in addition to those covered services specified in the contract. Additional covered services must be well defined in regards to amount, duration and scope, and must be approved in writing by the state prior to implementation.

The state requires the plans to have a quality improvement program that ensures enhancement of quality of care and emphasizes quality patient outcomes. If quality improvement and performance indicators based on HEDIS and other outcome measures are not met, the state may restrict the plan’s enrollment activities. Such restrictions may include the termination of mandatory assignments.

Plan members who require services covered through Medicaid but not covered by the plan may receive these services through the existing Medicaid fee-for-service reimbursement system. The MCOs and PAHPs are required to determine the need for these services and refer the member to the appropriate service provider. The plans may request the assistance of the local Medicaid Field Office for referral to the appropriate service setting.

The state requires the MCOs and PAHPs to have a quality improvement and quality utilization program, which includes, among others items, a service authorization system. The state approves the plans’ written services authorization system policies and procedures. The plans are required to maintain written confirmation of all denials of authorization to providers.

The reference to the contract provisions incorporating these requirements can be found in Table 17.

<table>
<thead>
<tr>
<th>Plan Type</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section II. A.3; Section VI. G, C.1.b; Section IX. A.1 and 3; Exhibit II-A, C.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section II, A.3.; Section VI. E and H.</td>
</tr>
</tbody>
</table>

**Table 17**

*Coverage of Services*

42 CFR 438.210(a)(1)(2)(3)

(b) Medically Necessary Services in Florida MCOs and PAHPs
The state requires that the MCO and PAHP contracts define the term “medically necessary or medical necessity” as “services provided in accordance with 42 CFR section 438.210(a)(4) and as defined in section 59G1.010(166), Florida Administrative Code, to include that medical or allied care, goods, or services furnished or ordered must meet the following conditions:

a) Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
b) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
c) Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
d) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available, statewide; and
e) Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee’s caretaker, or the provider.

“Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in itself, make such care, goods or services medically necessary, a medical necessity, or a covered service.”

The reference to the contract provisions incorporating this requirement can be found in Table 18.

<table>
<thead>
<tr>
<th>Plan Type</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section I, A.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section I, A.</td>
</tr>
</tbody>
</table>

(c) Written Policies and Procedures for Authorization of Services
The state requires the MCOs and PAHPs to comply with the following prior authorization requirements for family planning services:

- Pursuant to 42 CFR 431.51 (b), the plan shall allow each member to obtain family planning services from any participating Medicaid provider and require no prior authorization for such services. If the member receives services from a non-plan
Medicaid provider, then the plan must reimburse at the Medicaid reimbursement rate, unless another payment rate is negotiated.

The state requires the MCOs and PAHPs to comply with the following prior authorization requirements:

- The managed care plans will honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.

For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, if the services were prearranged prior to enrollment with the managed care plan:

1. Prior existing orders;
2. Provider appointments, e.g., dental appointments, surgeries, etc.;
3. Prescriptions (including prescriptions at non-participating pharmacies); and

The plans are required to comply with the following prior authorization requirements as they relate to behavioral health services:

- The plans cannot delay service authorization if written documentation is not available in a timely manner; however, the plan is not required to pay claims for which it has received no written documentation.
- The plans shall not deny claims submitted by a noncontracting provider solely based on the period between the date of service and the date of clean claim submission unless that period exceeds 365 days.
- The plans are responsible for payment of covered services to the existing treating provider at a prior negotiated rate or lesser of the provider's usual and customary rate or the established Medicaid fee-for-service rate for such services until the plan is able to evaluate the need for ongoing services.

The plans are required to comply with the following prior authorization requirements as they relate to out-of-plan non-emergency services:

- The plan shall provide timely approval or denial of authorization of out-of-plan use through the assignment of a prior authorization number, which refers to and documents the approval. A plan may not require paper authorization as a condition of receiving treatment if the plan has an automated authorization system. Written follow up documentation of the approval must be provided to the out-of-plan provider within one business day from the request for approval.

The state requires the plan's quality improvement program to include the following:

- The plan must develop and have in place utilization management policies and procedures that include protocols for prior approval and denial of services, hospital
discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria.

- The plan's service authorization systems shall provide authorization numbers, effective dates for the authorization, and written confirmation to the provider of denials, as appropriate. Pursuant to 42 CFR 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

The state requires the utilization management program to be consistent with 42 CFR 456 and include, but not be limited to, the following service authorization requirements:

- Service authorization protocols for prior authorization and denial of services; the process used to evaluate prior and concurrent authorization; mechanisms to ensure consistent application of review criteria for authorization decisions; consultation with the requesting Provider when appropriate; hospital discharge planning; physician profiling; and a retrospective review of both inpatient and ambulatory claims, meeting the predefined criteria below. The MCOs and PAHPs are responsible for ensuring the consistent application of review criteria for authorization decisions and consulting with the requesting provider when appropriate.

1. The managed care plan must have written approval from the Agency for its service authorization protocols and for any changes to the original protocols.

2. The plan’s service authorization systems shall provide the authorization number and effective dates for authorization to participating providers and non-participating providers.

3. The plan's service authorization systems shall provide written confirmation of all denials of authorization to providers. (See 42 C.F.R. 438.210(c)).

   i. The plan may request to be notified, but shall not deny claims payment based solely on lack of notification, for the following:

      (a) Inpatient emergency admissions (within ten days);

      (b) Obstetrical care (at first visit);

      (c) Obstetrical admissions exceeding forty-eight hours for vaginal delivery and ninety-six (96) hours for caesarean section; and

      (d) Transplants.

   ii. The plan shall ensure that all decisions to deny a service authorization request, or limit a service in amount, duration, or scope that is less than requested, are made by health care professionals who have the appropriate clinical expertise in treating the enrollee’s condition or disease. (See 42 C.F.R. 438.210(b)(3))

4. Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for behavioral health services. The psychiatrist's review shall be part of the UM process and not part of the clinical review. The provider or the enrollee may request a reconsideration after the issuance of a denial.
The plan shall provide post authorization to County Health Departments for the provision of emergency shelter medical screenings provided for clients of the Department of Children and Families (DCF).

Plans with automated authorization systems may not require paper authorization as a condition of receiving treatment.

The state requires the plans to comply with the following prior authorization requirement as it relates to foster care:

- The managed care plan shall provide a physical screening within seventy-two (72) hours, or immediately if required, for all enrolled children/adolescents taken into protective custody, emergency shelter or the foster care program by DCF. (See 65C-29.008, F.A.C.) The managed care plan shall provide these required examinations without requiring prior authorization, or, if a non-participating provider is utilized by DCF, approve and process the out-of-network claim.

The state requires the plans to provide to enrollees the plan’s authorization and referral process upon request:

- A detailed description of the plan’s authorization and referral process for health care services which shall include reasons for denial of services based on moral or religious grounds as required by section 1932(b)(3), Social Security Act;
- A detailed description of the plan’s process used to determine whether health care services are medically necessary;
- Policies and procedures relating to the plan’s prescription drug benefits program; and
- The decision-making process used for approving or denying experimental or investigational medical treatments.

The contract provisions incorporating the prior authorization requirements can be found in Table 19.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VI. G.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
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<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. H.</td>
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</tbody>
</table>

**Table 19**

*Service Authorization Policies & Procedures*

42 CFR 438.210(b)(d)(1)
(d) Decisions to Deny Services

The state requires the plan's quality improvement program to comply with 42 CFR 438.210(b)(3). Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.

The reference to the contract provision incorporating this requirement can be found in Table 20.

<table>
<thead>
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<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VI. G. 5. (1)</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. H. 5. (1)</td>
</tr>
</tbody>
</table>

C. Detailed Information Related to Access to Care Standards

1. Florida’s Mechanisms to Identify Individuals with Special Health Care Needs.

The Statewide Medicaid Managed Care Core Contract (Section I. Definitions and Acronyms) defines Enrollees with Special Health Care Needs as “Enrollees who face physical, behavioral or environmental challenges daily that place at risk their health and ability to fully function in society.”

Special health care needs include:

- Intellectual disabilities or related conditions, serious chronic illnesses, such as human immunodeficiency virus (HIV);
- Schizophrenia or degenerative neurological disorders;
- Disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes;
- Certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care; and
- All enrollees in LTC Managed Care Plans.

The state requires the MCOs and PAHPs to implement mechanisms for identifying, and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms shall include evaluation of health risk assessments, claims data, and, if
available CPT/ICD-10 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. In accordance 42 CFR 438.208(c)(3), a treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be developed by the enrollee’s care provider with enrollee participation and in consultation with any specialists caring for the enrollee; approved by the plan in a timely manner if this approval is required; and developed in accordance with any applicable state quality assurance and utilization review standards.

Pursuant to 42 CFR 438.208(c)(4), for enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with 42 CFR 438.208(c)(2)) and who need a course of treatment or regular care monitoring, the state requires each plan to have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee’s condition and identified needs.

The state requires the MCOs and PAHPs to assess new enrollees using a health risk assessment tool to identify persons with special health care needs. The MCO and PAHP contracts provide the following definition for Individuals with Special Health Care Needs - November 6, 2000 Report to Congress - Individuals with special health care needs are adults and children who daily face physical, mental, or environmental challenges that place at risk their health and ability to fully function in society. They include, for example, individuals with developmental disabilities; individuals with serious chronic illnesses such as Human Immunodeficiency Virus (HIV), schizophrenia, or degenerative neurological disorders; individuals with disabilities from many years of chronic illness such as arthritis, emphysema or diabetes; and children and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care. The state requires the MCOs and PAHPs to provide case management.

The state requires the plans to have an ongoing quality improvement (QI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its Medicaid population. The plan’s written policies and procedures shall address components of effective health care management including but not limited to anticipation, identification, monitoring, measurement, evaluation of enrollee’s health care needs, and effective action to promote quality of care. The plans are required to define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success. The plan and its quality improvement program are required to demonstrate in their care management how specific interventions better manage care and affect healthier patient outcomes. The goal shall be to provide comprehensive, high quality accessible, cost effective, and efficient health care to Medicaid enrollees. The state requires the plans to provide a written descriptive QI program that identifies full-time employed staff specifically trained to handle the Medicaid business and delineates how staffing is organized to interact and resolve problems, define measures and expectations, and
demonstrate the process for decision making (i.e., selection of projects and interventions) and reevaluation.

The reference to the contract provision incorporating this requirement can be found in Table 21.

<table>
<thead>
<tr>
<th>Plan Type</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section IX. A.3.; Exhibit II-A, E.7 and G.2.b.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section IX. A.3.</td>
</tr>
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</table>

2. Florida’s Identification Standards used to Determine the Extent to which Treatment Plans are Required to be Produced by MCOs and PAHPs for Individuals with Special Health Care Needs.

The state requires the MCOs and PAHPs to develop a treatment plan for enrollees who are determined to need a course of treatment or regular care monitoring by the enrollee’s care provider with enrollee participation and in consultation with any specialists caring for the enrollee. The treatment plan is required to be approved by the plan in a timely manner if approval is required, and the treatment plan must be developed in accordance with any applicable state quality assurance and utilization review standards.

The managed care plans will honor any written documentation of prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment, or until the enrollee's PCP or behavioral health provider (as applicable to medical care or behavioral health care services, respectively) reviews the enrollee's treatment plan, whichever comes first.

For all enrollees, written documentation of prior authorization of ongoing medical and behavioral health services includes the following, provided that the services were prearranged prior to enrollment with the managed care plan:

(1) Prior existing orders;
(2) Provider appointments (e.g., dental appointments, surgeries);
(3) Prescriptions (including prescriptions at non-participating pharmacies); and
(4) Behavioral health services.

The reference to the contract provisions incorporating this requirement can be found in Table 22.

<table>
<thead>
<tr>
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<td>MMA and LTC Program</td>
<td>Attachment II, Section VI. E. 2.d and 7.b.</td>
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<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
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<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. F.2. b; Section IX. A. 3, H. 2 and 3.</td>
</tr>
</tbody>
</table>


1. Provider Selection

The state requires the MCOs and PAHPs to comply with the requirements specified in 42 CFR 438.214, which include: selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. The state requires the plans to have written policies and procedures and a description of its policies and procedures for selection and retention of providers following the state’s policy for credentialing and recredentialing as specified in 42 CFR 438.214(a), 42 CFR 438.214(b)(1), and 42 CFR 438.214(b)(2). The state requires each plan to demonstrate that its providers are credentialed as specified in 42 CFR 438.206(b)(6), during the initial contract application process and during the annual on-site surveys and desk reviews. The state requires that the MCOs and PAHPs provider selection policies and procedures not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment as specified in 42 CFR 438.214(c). The state requires the plans to not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act as specified in 42 CFR 438.214(d).

The reference to the contract provisions incorporating this requirement can be found in Table 23.
Table 23
Provider Selection and Retention, Credentialing and Recredentialing, Nondiscrimination, and Excluded Providers
42 CFR 438.12(a)(2), 42 CFR 438.214(a)-(d), 42 CFR 438.206(b)(6)

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<tr>
<td>Dental Program</td>
<td>Attachment II, Section VIII. C. 2, 3, 4, and 5.</td>
</tr>
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2. Enrollee Information

The state requires the MCOs and PAHPs to make available the following items to members upon request:

- A detailed description of the plan’s authorization and referral process for health care services which shall include reasons for denial of services based on moral or religious grounds as required by section 1932(b)(3), Social Security Act (enacted in section 4704 of the Balanced Budget Act of 1997);
- A detailed description of the plan’s process used to determine whether health care services are medically necessary;
- A description of the plan’s quality improvement program;
- Policies and procedures relating to the plan’s prescription drug benefits program;
- Policies and procedures relating to the confidentiality and disclosure of the member’s medical records; and
- A detailed description of the plan’s credentialing process.

The state requires that immediately upon the assigned recipient’s enrollment in the plan, the plan must provide new enrollees the new member materials as provided below along with the required member information and member notification as specified in the plan’s contract:

The managed care plans will ensure that enrollees are notified of their rights and responsibilities; the role of primary care physicians; how to obtain care; what to do in an emergency or urgent medical situation; how to pursue a complaint, a grievance, appeal or Medicaid Fair Hearing; how to report suspected fraud and abuse; how to report abuse, neglect and exploitation; and all other requirements and benefits of the managed care plan.

The managed care plans will provide enrollee information in accordance with 42 CFR 438.10, which addresses information requirements related to written and oral information provided to enrollees, including: languages; format; managed care plan
features, such as benefits, cost sharing, provider network and physician incentive plans; enrollment and disenrollment rights and responsibilities; grievance system; and advance directives. The managed care plans will notify enrollees, on at least an annual basis, of their right to request and obtain information in accordance with the above requirements.

- Procedures for filing a request for disenrollment for cause. As noted in the section, the state-approved for-cause reasons listed must be listed verbatim in the disenrollment section of the enrollee handbook. In addition, the managed care plan shall include the following language verbatim in the disenrollment section of the enrollee handbook:

  “Some Medicaid recipients may change managed care plans whenever they choose, for any reason. To find out if you may change plans, call the Enrollment Broker [INSERT APPROPRIATE TELEPHONE NUMBER].”

- Information regarding newborn enrollment, including the mother’s responsibility to notify the Managed Care Plan and DCF of the pregnancy and the newborn’s birth;
- Enrollee rights and responsibilities, including the extent to which and how enrollees may obtain services from non-participating providers and other provisions in accordance with 42 CFR 438.100;
- Description of services provided, including limitations and general restrictions on provider access, exclusions and out-of-network use, and any restrictions on enrollee freedom of choice among participating providers;
- Procedures for obtaining required services, including second opinions at no expense to the enrollee (in accordance with 42 CFR 438.206(3) and s. 641.51, F.S.), and authorization requirements, including any services available without prior authorization;
- The extent to which, and how, after hours and emergency coverage is provided, and that the enrollee has a right to use any hospital or other setting for emergency care;
- Cost sharing for the enrollee, if any;
- Information that interpretation services and alternative communication systems are available, free of charge, including for all foreign languages and vision and hearing impairment, and how to access these services;
- How and where to access any benefits that are available under the Medicaid State Plan but are not covered under this Contract, including any cost sharing;
- Procedures for reporting fraud, abuse and overpayment that includes the following language verbatim:

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/
If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

- Clear specifics on the required procedural steps in the grievance process, including the address, telephone number and office hours of the grievance staff. The managed care plan shall specify telephone numbers to call to present a complaint, grievance, or appeal. Each telephone number shall be toll-free within the caller’s geographic area and provide reasonable access to the managed care plan without undue geographic delays;
- Fair Hearing procedures;
- Information that services will continue upon appeal of a denied authorization and that the enrollee may have to pay in case of an adverse ruling;
- Information regarding HIPAA relative to the enrollee’s personal health information (PHI);
- Information to help the enrollee assess a potential behavioral health problem;
- Procedures for reporting abuse, neglect, and exploitation, including the abuse hotline number: 1-800-96-ABUSE;
- Information regarding health care advance directives pursuant to ss. 765.302 through 765.309, F.S., 42 CFR 438.6(i)(1)-(4) and 42 CFR 422.128;
- The managed care plan’s information shall include a description of state law and must reflect changes in state law as soon as possible, but no later than ninety (90) days after the effective change;
- The managed care plan shall provide these policies and procedures to all enrollee’s age 18 and older and shall advise enrollees of the enrollee’s rights under state law, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

The managed care plan’s written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;

- The managed care plan’s information shall inform enrollees that complaints about noncompliance with advance directive laws and regulations may be filed with the state’s complaint hotline;
- The managed care plan shall educate enrollees about their ability to direct their care using this mechanism and shall specifically designate which staff and/or participating providers are responsible for providing this education;
- How to get information about the structure and operation of the managed care plan and any physician incentive plans, as set forth in 42 CFR 438.10(g)(3);
- Instructions explaining how enrollees may obtain information from the managed care plan about how it rates on performance measures in specific areas of service;
• How to obtain information from the managed care plan about quality enhancements (QEs) as specified in Section V.F.; and
• Toll-free telephone number of the appropriate Medicaid Area Office and Aging and Disability Resource Centers.

The state requires the plans to provide enrollee information in accordance with 42 CFR 438.10(f), including notification to enrollees at least on an annual basis of their right to request and obtain information.

The reference to the contract provisions incorporating this requirement can be found in Table 24.

### Table 24

<table>
<thead>
<tr>
<th>Enrollee Information</th>
<th>Section 1932(b)(3), of Social Security Act and 42 CFR 438.10(f)</th>
</tr>
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<tbody>
<tr>
<td>Plan Type</td>
<td>Contract Provision</td>
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<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section V. A, B, and C; Section VI; Section VII; Exhibit II-A, Section VII.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section V; Section VI; Section VII</td>
</tr>
</tbody>
</table>

3. Confidentiality

During the initial MCO and PAHP contract application process, the state ensures the plans establish and implement procedures consistent with Federal and state regulations including confidentiality requirements in 45 CFR parts 160 and 164, and 42 CFR 438.224. The managed care plan shall have a policy to ensure the confidentiality of medical records in accordance with 42 CFR, Part 431, Subpart F. This policy shall also include confidentiality of a minor’s consultation, examination, and treatment for a sexually transmissible disease in accordance with s. 384.30(2), F.S.

The state conducts annual on-site surveys and desk reviews to ensure the plans maintain procedures consistent with state and Federal regulations.

The reference to the contract provisions incorporating this requirement can be found in Table 25.
### Table 25

**Confidentiality**

45 CFR parts 160 and 164, 42 CFR 438.224

<table>
<thead>
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<th>Plan Type</th>
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</tr>
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<td><strong>Prepaid Health Plans</strong></td>
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<tr>
<td>Dental Program</td>
<td>Attachment II, Section XV, T.</td>
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4. **Enrollment & Disenrollment**

The state or its agent is responsible for all enrollments, including enrollment into the plan, disenrollment, and outreach and education activities. The state requires the plans to coordinate with the state or its agent as necessary for all enrollment and disenrollment functions. The state also requires the plans to accept Medicaid recipients without restriction and in the order in which the recipients enroll. The state specifies in the plan's contract that the plan cannot discriminate against Medicaid recipients on the basis of religion, gender, race, color, age, or national origin, and shall not use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color, or national origin, or on the basis of health, health status, preexisting condition, or need for health care services. The plans are required to accept new enrollees throughout the contract period up to the authorized maximum enrollment levels approved in each plan's contract.

Prior to or upon enrollment, the state requires the plans to provide the following information to all new enrollees:

- A written notice providing the actual date of enrollment, and the name, telephone number and address of the enrollee's primary care provider assignment;
- Notification that enrollees can change their plan selection, subject to Medicaid limitations;
- Enrollment materials regarding PCP choice as described in the plan contract; and
- New enrollee materials as described in the managed care plan contract.

The state requires the plans to comply with the following general disenrollment requirements, which are specified in each MCO and PAHP contract:

- If the plan's contract is renewed, the enrollment status of all enrollees shall continue uninterrupted.
- The plan shall ensure that it does not restrict the enrollee's right to disenroll voluntarily in any way.
c. The plan or its agents shall not provide or assist in the completion of a disenrollment request or assist the Agency’s choice counselor/enrollment broker in the disenrollment process.

d. The plan must ensure that enrollees that are disenrolled and wish to file an appeal have the opportunity to do so. All enrollees shall be afforded the right to file an appeal except for the following reasons for disenrollment:

(1) Moving out of the service area;
(2) Loss of Medicaid eligibility; and
(3) Enrollee death.

e. An enrollee may submit to the state or its agent a request to disenroll from the plan without cause during the 90 calendar day change period following the date of the enrollee's initial enrollment with the plan, or the date the state or its agent sends the enrollee notice of the enrollment, whichever is later. An enrollee may request disenrollment without cause every 12 months thereafter.

f. The effective date of an approved disenrollment shall be the last calendar day of the month in which disenrollment was made effective by the state or its agent, but in no case shall disenrollment be later than the first calendar day of the second month following the month in which the enrollee or the plan files the disenrollment request. If the state or its agent fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

g. The plan shall keep a daily written log or electronic documentation of all oral and written enrollee disenrollment requests and the disposition of such requests. The log shall include the following:

(1) The date the request was received by the plan;
(2) The date the enrollee was referred to the state’s choice counselor/enrollment broker or the date of the letter advising the enrollee of the disenrollment procedure, as appropriate; and
(3) The reason that the enrollee is requesting disenrollment.

h. The managed care plans shall promptly submit disenrollment requests to the Agency. In no event shall the managed care plans submit a disenrollment request at such a date as would cause the disenrollment to be effective later than forty-five (45) days after the managed care plan’s receipt of the reason for involuntary disenrollment. The managed care plan shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

The state specifies the following regarding involuntary disenrollment in the MCO and PAHP contracts:

a. With proper written documentation, the managed care plans may submit involuntary disenrollment requests to the Agency or its enrollment broker in a manner prescribed by the Agency. The following are acceptable reasons for which the managed care plans may submit involuntary disenrollment requests:
(1) Fraudulent use of the enrollee identification (ID) card. In such cases the managed care plan shall notify MPI of the event.

(2) Falsification of prescriptions by an enrollee. In such cases the managed care plan shall notify MPI of the event.

(3) The enrollee’s behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the managed care plan seriously impairs the organization’s ability to furnish services to either the enrollee or other enrollees.

   a) This provision does not apply to enrollees with medical or mental health diagnoses if the enrollee’s behavior is attributable to the diagnoses.

   b) An involuntary disenrollment request related to enrollee behavior must include documentation that the managed care plan:

      (i) Provided the enrollee at least one (1) oral warning and at least one (1) written warning of the full implications of the enrollee’s actions;

      (ii) Attempted to educate the enrollee regarding rights and responsibilities;

      (iii) Offered assistance through care coordination/case management that would enable the enrollee to comply; and

      (iv) Determined that the enrollee’s behavior is not related to the enrollee’s medical or mental health condition.

(4) The enrollee will not relocate from an assisted living facility or adult family care home that does not, and will not conform to HCB characteristics required under the managed care plan’s contract.

   b. The plan shall promptly submit such disenrollment requests to the state. In no event shall the plan submit the disenrollment request at such a date as would cause the disenrollment to be effective later than 45 calendar days after the plan’s receipt of the reason for involuntary disenrollment. The plan shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

   c. If the plan submitted the disenrollment request for one of the above reasons, the plan shall verify that the information is accurate.

   d. If the plan discovers that an ineligible enrollee has been enrolled, then it shall request disenrollment of the enrollee and shall notify the enrollee in writing that the plan is requesting disenrollment and the enrollee will be disenrolled in the next contract month, or earlier if necessary. Until the enrollee is disenrolled, the plan shall be responsible for the provision of services to that enrollee.

   e. On a monthly basis, the plan shall review its ongoing enrollment report to ensure that all enrollees are residing in the plan’s authorized service area. For enrollees with out-of-service area addresses on the enrollment report, the plan shall notify the enrollee in writing that the enrollee should contact the choice counselor/enrollment broker to choose another plan, or other managed care option available in the enrollee’s new service area, and that the enrollee will be disenrolled.
f. The plan may submit involuntary disenrollment requests to the state or its agent for assigned enrollees who meet both of the following requirements:

1) The plan was unable to contact the enrollee by mail, phone, or personal visit within the first three months of enrollment; and

2) The enrollee did not use plan services within the first three months of enrollment. Such disenrollments must be submitted in accordance with the reporting requirements specified in the plan’s contract. The plan shall maintain documentation of its inability to contact the enrollee and that it has no record of providing services to the enrollee, or to another family unit member, in the enrollee’s file.

g. The plan may submit an involuntary disenrollment request to the state or its agent after providing to the enrollee at least one verbal warning and at least one written warning of the full implications of his/her failure of actions:

1) For an enrollee who continues not to comply with a recommended plan of health care or misses three consecutive appointments within a continuous six month period. Such requests must be submitted at least 60 calendar days prior to the requested effective date.

2) For an enrollee whose behavior is disruptive, unruly, abusive or uncooperative to the extent that his or her enrollment in the plan seriously impairs the organization’s ability to furnish services to either the enrollee or other enrollees. This section of the plan’s contract does not apply to enrollees with mental health diagnoses if the enrollee’s behavior is attributable to the mental illness.

h. The state may approve such requests provided that the plan documents that attempts were made to educate the enrollee regarding his/her rights and responsibilities, assistance which would enable the enrollee to comply was offered through case management, and it has been determined that the enrollee’s behavior is not related to the enrollee’s medical or behavioral condition. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the state. Any request not approved is final and not subject to dispute or appeal.

i. The plan shall not request disenrollment of an enrollee due to:

1) Health diagnosis;

2) Adverse changes in an enrollee’s health status;

3) Utilization of medical services;

4) Diminished mental capacity;

5) Pre-existing medical condition;

6) Uncooperative or disruptive behavior resulting from the enrollee’s special needs (with the exception of g.2 above);

7) Attempt to exercise rights under the plan’s grievance system; or
8) Request of one (1) primary care provider to have an enrollee assigned to a different provider out of the plan.

The state requires the MCOs and PAHPs to ensure that all community outreach, pre-enrollment, enrollee, disenrollment, and grievance materials developed for the Medicaid population adhere to the following policies and procedures:

a. All materials developed for the Medicaid population must be at or near the fourth-grade comprehension level so that the materials are understandable (in accordance with section 1932(a)(5) of the Social Security Act as enacted by section 4701 of the Balanced Budget Act of 1997), and be available in alternative communication methods (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities.

b. The plan shall assure that appropriate foreign language versions of all materials are developed and available to members and potential members. The plan shall provide interpreter services in person where practical, but otherwise by telephone, for applicants or members whose primary language is a foreign language. Foreign language versions of materials are required if, as provided annually by the Agency, the population speaking a particular foreign (non-English) language in a county is greater than five percent.

c. The managed care plan shall not market nor distribute any marketing materials without first obtaining Agency approval. The managed care plan shall ensure compliance with its contract and all state and federal marketing requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the managed care plan.

The state specifies the following requirements in the MCO and PAHP contracts:

a. Prohibited marketing, enrollment and disenrollment activities and practices;

b. Permitted activities under the supervision of the Agency for Health Care Administration regarding marketing, enrollment and disenrollment;

c. Requirements for the community outreach notification process;

d. Requirements for provider compliance;

e. Requirements for community outreach representatives;

f. Pre-enrollment activities and requirements;

g. Enrollment activities and requirements;

h. Behavioral health enrollment activities and requirements;

i. Newborn enrollment activities and requirements;

j. Enrollment levels;

k. Disenrollment requirements;

l. Voluntary disenrollment requirements; and

m. Involuntary disenrollment requirements.
The managed care plans shall ensure compliance with their contract and all state and federal marketing requirements, including monitoring and overseeing the activities of its subcontractors and all persons acting for, or on behalf of, the managed care plan (see 42 CFR 438.104; s. 409.912, F.S.; s. 641.3901, F.S.; s. 641.3903, F.S.; s. 641.386, F.S., s. 626.112, F.S.; s. 626.342, F.S.; s. 626.451, F.S.; s. 626.471, F.S.; s. 626.511, F.S.; and s. 626.611, F.S.). If the Agency finds that a managed care plan failed to comply with applicable contract, federal or state marketing requirements, the Agency may take compliance action, including sanctions.

The MCOs and PAHPs are permitted by contract to engage in the following activities under the supervision and with the written approval of the state:

a. The plan may attend health fairs/public events upon request by the sponsor and after written notification to the state.

b. Choice counselor/enrollment broker. State approval of the script used by the plan’s member services section must be obtained before usage.

c. The reference to the contract provisions incorporating these requirements can be found in Table 26.

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**Table 26**

**Enrollment & Disenrollment**


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<td>Dental Program</td>
<td>Attachment II, Section III. C and D.; Section IV; Section V</td>
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1. **Grievance System**

The state requires the MCOs and PAHPs to develop, implement, and maintain a grievance system that complies with federal laws and regulations, including 42 CFR 431.200 and 438, Subpart F, Grievance System. The state requires the plan’s member service handbook to include information on the plan’s grievance system components.

The state requires the MCOs’ and capitated PAHPs’ grievance systems to include:

a. The plan may leave state community outreach materials at health fairs/public events at which the plan participates.
b. The plan may provide state-approved community outreach materials. Such materials may include Medicaid enrollment and eligibility information and information related to other health care projects and health, welfare and social services provided by the state or local communities. The plan staff, including community outreach representatives, shall refer all plan inquiries to the member services section of the plan or the state’s external grievance resolution process as created in section 408.7056, Florida Statutes. The state’s fee-for-service provider service networks do not have access to the external grievance resolution process established in section 408.7056, Florida Statutes. For those provider service networks only, the state requires the grievance system to include an external grievance resolution process referred to as the Beneficiary Assistance Program, which is operated by Florida Medicaid and modeled after the external grievance resolution process pursuant to section 408.7056, Florida Statutes.

The state requires all of the MCOs’ and PAHPs’ grievance systems to include written policies and procedures that are approved, in writing, by the state. Other state requirements include the following:

a. The plans must give enrollees reasonable assistance in completing forms and other procedural steps, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

b. The plans must acknowledge receipt of each grievance and appeal.

c. The plans must ensure that decision makers about grievances and appeals were not involved in previous levels of review or decision making and are health care professionals with appropriate clinical expertise in treating the enrollee’s condition or disease when deciding any of the following:

- An appeal of a denial based on lack of medical necessity;
- A grievance regarding denial of expedited resolution of an appeal; or
- A grievance or appeal involving clinical issues.

d. The plans must provide information regarding the grievance system to enrollees as described in the plan’s contract. The information shall include, but not be limited to:

1) Enrollee rights to file grievances and appeals and requirements and time frames for filing.

2) The availability of assistance in the filing process.

3) The address, toll-free telephone number, and the office hours of the grievance coordinator.

4) The method for obtaining a Medicaid fair hearing, the rules that govern representation at the hearing, and the address for pursuing a fair hearing, which is:

   Agency for Health Care Administration
   Office of Fair Hearings
   P.O. Box 60127
   Ft. Myers, Florida 33906
   Phone: 1-877-254-1055
5) A description of the external grievance resolution process, the types of grievances and appeals that can be submitted and directions for doing so.

6) A statement assuring enrollees that the plan, its providers or the state will not retaliate against an enrollee for submitting a grievance, an appeal or a request for a Medicaid fair hearing.

7) Enrollee rights to request continuation of benefits during an appeal or Medicaid fair hearing process and, if the plan's action is upheld in a hearing, the fact that the enrollee may be liable for the cost of said benefits.

8) Notice that the MCO or PAHP must continue enrollee benefits if:
   a) The appeal is filed timely, meaning on or before the later of the following:
      i. Within ten calendar days of the date on the notice of action (15 calendar days if the notice is sent via surface mail), and
      ii. The intended effective date of the MCO or PAHP proposed action.
   b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
   c) The services were ordered by an authorized provider.
   d) The authorization period has not expired.
   e) The enrollee requests extension of benefits.

9) The plan must provide information about the grievance system and its respective policies, procedures, and timeframes, to all providers and subcontractors at the time they enter into a subcontract/provider contract. The plan must clearly specify all procedural steps in the provider manual, including the address, telephone number, and office hours of the Grievance coordinator.

   e. The plan must maintain records of grievances and appeals for tracking and trending for QI and to fulfill reporting requirements as described in the plan’s contract.

2. Grievance Process

The state requires the MCOs and PAHPs to comply by contract with the following grievance process requirements.

a. Filing a Grievance
   1) A grievance is any expression of dissatisfaction by an enrollee, about any matter other than an Action. A provider, acting on behalf of the enrollee and with the enrollee’s written consent, may also file a grievance.
   2) A grievance can be filed orally.

b. Grievance Resolution
   1) The plan must resolve each grievance and provide the enrollee with a notice of the grievance disposition within 90 days of its receipt.
   2) The grievance must be resolved more expeditiously, within 24 hours, if the enrollee's health condition requires, as found in s. 409.91211(3)(q), F.S.
3) The notice of disposition must be in writing and include the results and the date of grievance resolution.
4) The plan must provide the Agency with a copy of the notice of disposition upon request.
5) The plan must ensure that punitive action is not taken against a provider who files a grievance on an enrollee’s behalf or supports an enrollee’s grievance as required in s. 409.9122(12), F.S.

The state requires the MCOs and PAHPs to comply by contract with the following appeals process requirements.

a. **Filing an Appeal:**

   1) An enrollee may request a review of a health plan action by filing an appeal.
   2) An enrollee may file an appeal, and a provider, acting on behalf of the enrollee and with the enrollee’s written consent, may file an appeal. The appeal procedure must be the same for all enrollees.
   3) The appeal must be filed within 30 days of the date of the notice of action. If the plan fails to issue a written notice of action, the enrollee or provider may file an appeal within one (1) year of the action.
   4) The enrollee or provider may file an appeal either orally or in writing and may follow an oral filing with a written, signed appeal. For oral filings, time frames for resolution begin on the date the plan receives the oral filing.

b. **Resolution of Appeals**

The plan must:

1) Ensure that oral inquiries seeking to appeal an action are treated as appeals and acknowledge receipt of those inquiries, as well as written appeals, in writing, unless the enrollee or the provider requests expedited resolution.
2) Provide a reasonable opportunity for the enrollee/provider to present evidence, and allegations of fact or law, in person as well as in writing.
3) Allow the enrollee and their representative the opportunity, before and during the appeals process, to examine the enrollee’s case file, including medical records and any other documents and records.
4) Consider the enrollee representative or estate representative of a deceased enrollee as parties to the appeal.
5) Resolve each appeal and provide notice within 45 days from the day the plan receives the appeal.
6) Resolve the appeal more expeditiously if the enrollee’s health condition requires.
   7) The plan may extend the resolution time frames by up to 14 calendar days if the enrollee requests the extension or the plan documents that there is need for additional information and that the delay is in the enrollee’s interest. If the extension is not requested by the enrollee, the plan must give the enrollee written notice of the reason for the delay.
8) Continue the enrollee’s benefits if:
   a) The appeal is filed timely, meaning on or before the later of the following:
i. Within ten calendar days of the date on the notice of action or 15 calendar days if sent by surface mail, or

ii. The intended effective date of the plan’s proposed action.

b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

c) The services were ordered by an authorized provider.

d) The authorization period has not expired.

e) The enrollee requests extension of benefits.

9) If the plan continues or reinstates enrollee benefits while the appeal is pending, the benefits must be continued until one of following occurs: a) The enrollee withdraws the appeal;

a) Ten calendar days (15 calendar days if the notice is sent via surface mail) pass from the date of the plan’s adverse decision, and the enrollee has not requested a Medicaid fair hearing with continuation of benefits;

b) A Medicaid fair hearing decision adverse to the enrollee is made; or

c) The authorization expires or authorized service limits are met.

10) Provide written notice of disposition that includes the results and date of appeal resolution, and for decisions not wholly in the enrollee’s favor, also includes: a) Notice of the enrollee’s right to request a Medicaid fair hearing;

a) Information about how to request a Medicaid fair hearing, including the address for pursuing a Medicaid fair hearing, which is:

Agency for Health Care Administration
Office of Fair Appeal Hearings
P.O. Box 60127
Ft. Myers, Florida 33906
Phone: 1-877-254-1055
Fax: 239-338-2642
Email: MedicaidHearingUnit@ahca.myflorida.com

b) Notice of the right to continue to receive benefits pending a Medicaid fair hearing;

c) Information about how to request the continuation of benefits; and

d) Notice that if the plan’s action is upheld in a Medicaid fair hearing, the enrollee may be liable for the cost of any continued benefits.

11) Provide the Agency with a copy of the written notice of disposition upon request.

12) Ensure that punitive action is not taken against a provider who files an appeal on an enrollee’s behalf or supports an enrollee’s appeal.
c. Post Appeal Resolution:

1) If the final resolution of the appeal in a fair hearing is adverse to the enrollee, the Agency may recover the cost of the services furnished while the appeal was pending, to the extent that they were furnished solely because of the requirements of this section.

2) The plan must authorize or provide the disputed services promptly, and as expeditiously as the enrollee’s health condition requires, if the services were not furnished while the appeal was pending and the disposition reverses a decision to deny, limit, or delay services.

3) The plan must pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the appeal was pending and the disposition reverses a decision to deny, limit, or delay services.

a. Expedited Process

1) The plan must establish and maintain an expedited review process for grievances and appeals when the plan determines (if requested by the enrollee) or the provider indicates (in making the request on the enrollee’s behalf or supporting the enrollee’s request) that taking the time for a standard resolution could seriously jeopardize the enrollee’s life or health or ability to attain, maintain, or regain maximum function.

2) The enrollee or provider may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required. The plan must inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and/or in writing.

3) Resolve each expedited appeal and provide notice, as expeditiously as the enrollee’s health condition requires, not to exceed 72 hours after the plan receives the appeal.

4) The plan must provide written notice of disposition that includes the results and date of expedited appeal resolution, and for decisions not wholly in the enrollee’s favor, that includes:

   a) Notice of the enrollee’s right to request a Medicaid fair hearing;

   b) Information about how to request a Medicaid fair hearing, including the address for pursuing a fair hearing, which is:

   Agency for Health Care Administration
   Office of Fair Appeal Hearings
   P.O. Box 60127
   Ft. Myers, Florida 33906
   Phone: 1-877-254-1055
   Fax: 239-338-2642
   Email: MedicaidHearingUnit@ahca.myflorida.com

   c) Notice of the right to continue to receive benefits pending a hearing;

   d) Information about how to request the continuation of benefits; and
e) Notice that if the plan’s action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits.

5) If the plan denies a request for expedited resolution of an appeal, the plan must:
   a) Transfer the appeal to the standard time frame of no longer than 45 days from the day the plan receives the appeal with a possible 14-day extension;
   b) Make reasonable efforts to provide prompt oral notice of the denial;
   c) Provide written notice of the denial within two calendar days; and
   d) Fulfill all general plan duties listed above.

7. Medicaid Fair Hearing System
   a. Request for Medicaid Fair Hearing
      1) An enrollee may request a Medicaid fair hearing either upon receipt of a notice of action from the plan or upon receiving an adverse decision from the plan, after filing an appeal with the plan.
      2) A provider, acting on behalf of the enrollee and with the enrollee’s written consent, may request a Medicaid fair hearing under the same circumstances as the Enrollee.
      3) Parties to the Medicaid fair hearing include the plan, as well as the enrollee and his or her representative or the representative of a deceased enrollee’s estate.
      4) The enrollee or provider may request a Medicaid fair hearing within 90 calendar days of the date of the notice of action from the plan regarding an enrollee appeal.
      5) The enrollee or provider may request a Medicaid fair hearing by contacting the Agency for Health Care Administration at:

         Office of Fair Hearings
         P.O. Box 60127
         Ft. Myers, Florida 33906
         Phone: 1-877-254-1055
         Fax: 239-338-2642
         Email: MedicaidHearingUnit@ahca.myflorida.com

   b. The Plan Responsibilities
      The plan must:
      1) Continue the enrollee’s benefits while the Medicaid fair hearing is pending if:
         a) The Medicaid fair hearing is filed timely, meaning on or before the later of the following:
            i. Within ten calendar days of the date on the notice of action (15 calendar days if the notice is sent via surface mail); or
            ii. The intended effective date of the plan’s proposed action.
b) The Medicaid fair hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;

c) The services were ordered by an authorized provider;

d) The authorization period has not expired; or
e) The enrollee requests extension of benefits.

2) Ensure that punitive action is not taken against a provider who requests a Medicaid fair hearing on the enrollee’s behalf or supports an enrollee’s request for a Medicaid fair hearing.

3) If the plan continues or reinstates enrollee benefits while the Medicaid fair hearing is pending, the benefits must be continued until one of the following occurs: a) The enrollee withdraws the request for a Medicaid fair hearing;

b) Ten calendar days pass from the date of the plan’s adverse decision and the enrollee has not requested a Medicaid fair hearing with continuation of benefits until a Medicaid fair hearing decision is reached. (15 calendar days if the notice is sent via surface mail);

c) A Medicaid fair hearing decision adverse to the enrollee is made; or

d) The authorization expires or authorized service limits are met.

B. Post Medicaid Fair Hearing Decision

1) If the final resolution of the Medicaid fair hearing is adverse to the enrollee, the plan may recover the cost of the services furnished while the Medicaid fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

2) The plan must authorize or provide the disputed services promptly, and as expeditiously as the enrollee’s health condition requires, if the services were not furnished while the Medicaid fair hearing was pending and the Medicaid fair hearing officer reverses a decision to deny, limit, or delay services.

3) The plan must pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Medicaid fair hearing was pending and the Medicaid fair hearing officer reverses a decision to deny, limit, or delay services.

The plan’s grievance system is monitored by the state through on-site surveys, desk reviews and reports to the state. The annual on-site survey conducted by the state looks at a sample of the plan’s grievance files. The annual desk review monitors the plan’s policies and procedures and member materials for compliance with all state and federal regulations. The state requires the plans to submit a quarterly report on new and outstanding grievances to the state.

The reference to the contract provisions incorporating these requirements can be found in Table 27.

| Table 27 |
| Grievance System |
| 42 CFR 431.200 and 438, Subpart F |
8. Subcontractual Relationship & Delegation

The state requires the plans to oversee and holds the plans accountable for any functions and responsibilities that it delegates to any subcontractor pursuant to 42 CFR 438.6 and 42 CFR 438.230 including:

- All plan subcontracts are required to fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
- The plans' contracts require that the plan evaluate the prospective subcontractor's ability to perform the activities to be delegated.
- The plans' contracts require a written agreement between the plan and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- The plans' contracts require that each plan monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the state, consistent with industry standards or the applicable laws and regulations.
- The plans' contracts require that if the plan identifies deficiencies or areas for improvement, the plan and the subcontractor must take corrective action.

During the initial MCO and PAHP contracting process, the state ensures the plans' subcontractual relationships and delegations comply with 42 CFR 438.6 and 42 CFR 438.230. The state conducts annual on-site surveys and desk reviews of the plans to ensure each plan's subcontractual relationships and delegations remain in compliance with 42 CFR 438.6 and 438.230.

The references to the contract provision incorporating this requirement can be found in Table 28.

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<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
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<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section VII.</td>
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<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
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<tr>
<td>Dental Program</td>
<td>Attachment II, Section VII.</td>
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Table 28

Subcontracted Relationships & Delegation
42 CFR 438.6 and 42 CFR 438.230

<table>
<thead>
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<th>Plan Type</th>
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</table>
E. Detailed Information Related to Florida's Structure and Operation Standards

The state requires the plans to have a grievance system for enrollees that include a grievance process, an appeal process, and access to the Medicaid fair hearing system in compliance with 42 CFR 431.200 and 438, Subpart F. The plan's grievance system is monitored by the state through annual on-site surveys, desk reviews and reports submitted quarterly to the state.

Other components of the MCO and PAHP contracts that are reviewed by the state during the onsite survey include:

- Administration and Management Policy and Procedures
- Staffing
- Disaster Plan
- Minority Retention and Recruitment Plan
- Insurance documents
- Member Identification Care
- Credentialing and Recredentialing Policy and Procedures
- Credentialing files
- Medical Record Requirements Policy and Procedures
- Member Handbook
- Provider Directories
- Board Meeting and Committee Meeting Minutes
- Quality Improvement Policy and Procedures
- Member Services and Enrollment Policy and Procedures
- Utilization Management Policy and Procedures
- Case Management/Continuity of Care Policy and Procedures
- Community Outreach Policy and Procedures
- Community Outreach Staff Qualifications and Credentials
- Community Outreach Plan
- Behavioral Health Policy and Procedures
- Provider Networks
- Provider Site Visit Form
- Grievance and Appeals Policy and Procedures
- Grievance and Appeals Letters
- Quality Benefit Enhancements
- Organization Chart
- Information Systems
- Model Subcontracts (Primary Care Provider, Specialty Care Provider, Ancillary Care Agreement)
- Hospital Service Agreement

1. Practice Guidelines

Pursuant to 42 CFR 438.236(b), the state requires the MCOs and PAHPs to adopt practice guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Consider the needs of the enrollees;
- Are adopted in consultation with contracting health care professionals; and
- Are reviewed and updated periodically as appropriate.

The state requires that the MCOs and PAHPs disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. This section specifies that decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply shall be consistent with the guidelines.

The reference to the contract provision incorporating these requirements can be found in Table 29.

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<tr>
<td>Dental Program</td>
<td>Attachment II, Section VI. H. 4.</td>
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2. Quality Assessment & Performance Improvement Program

The state requires the MCOs and PAHPs to have an ongoing quality improvement (QI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its Medicaid population. The plans’ written policies and procedures are required to address components of effective health care management including, but not limited to, anticipation, identification, monitoring, measurement, and evaluation of enrollee’s health care needs, and effective action to promote quality of care. The plans are required to define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success. Each plan and the plan’s quality improvement program is required to demonstrate in each plan’s care management how specific interventions better manage care and impact healthier patient
outcomes to achieve the goal of providing comprehensive, high quality, accessible, cost effective, and efficient health care to Medicaid enrollees. Pursuant to 42 CFR 438.208(c)(1), the state requires the plans to implement mechanisms to identify persons with special health care needs, as those persons are defined by the state.

The state requires the plans to provide a written descriptive QI program that identifies staff specifically trained to handle the Medicaid business and delineates how staffing is organized to interact and resolve problems, define measures and expectations, and demonstrate the process for decision making (i.e., project selection, interventions) and reevaluation.

The references to the contract provision incorporating this requirement can be found in Table 30.

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<th>Plan Type</th>
<th>Contract Provision</th>
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<tr>
<td><strong>Managed Care Organizations</strong></td>
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<tr>
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<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
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<tr>
<td>Dental Program</td>
<td>Attachment II, Section IX.</td>
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The state requires the plans to cooperate with the state and the External Quality Review Organization (EQRO) vendor. The state sets methodology and standards for QI performance improvement with advice from the EQRO. Prior to implementation, the state reviews each plan’s QI program. Each plan’s quality improvement program must be approved, in writing, by the state no later than three months following the effective date of the contract. If a plan has submitted and received approval for the present calendar year, an extension may be granted for the submission of new projects.

The state requires that the MCOs’ and PAHPs’ quality improvement programs be based on the minimum requirements listed below.

(a) The plan’s QI governing body shall monitor, evaluate, and oversee results to improve care. The governing body shall have written guidelines and standards defining their responsibilities for:

- Supervision and maintenance of an active QI committee;
- Ensuring ongoing QI activity coordination with other management activity, demonstrated through written, retrievable documentation from meetings or activities;
- Planning, decisions, interventions, and assessment of results to demonstrate coordination of QI processes;
- Oversight of QI program activities; and
- A written diagram that demonstrates the QI system process.

(b) Each plan is required to have a quality improvement review authority which shall:
- Direct and review quality improvement activities;
- Assure that quality improvement activities take place throughout the plan;
- Review and suggest new or improved quality improvement activities;
- Direct task forces/committees in the review of focused concern;
- Designate evaluation and study design procedures;
- Publicize findings to appropriate staff and departments within the plan;
- Report findings and recommendations to the appropriate executive authority; and
- Direct and analyze periodic reviews of members’ service utilization patterns.

(c) Each plan is required to provide for quality improvement staff specifically trained to handle the Medicaid business which have the responsibility for: identifying their Medicaid enrollees’ needs and problems related to quality of care for covered health care and professional services, measuring how well these needs are met, and improving processes to meet these needs. Each plan is required to evaluate ways in which care is provided, identify outliers to specific indicators, determine what shall be accomplished, ascertain how to determine if a change is an improvement, and initiate interventions that will result in an improved quality of care for covered health care and professional services. Each plan is required to prioritize problem areas for resolution and design strategies for change, implement improvement activities and measure success.

(d) The systematic process of quality assessment and improvement shall be objective in systematically monitoring and evaluating the quality and appropriateness of care and service delivery (or the failure of delivery) to the Medicaid population through quality of care projects and related activities. Opportunities for improvement shall be identified on an ongoing basis. The plans are required to assess, evaluate, decrease inappropriate care, decrease inappropriate service denials, and increase coordination of care. The plans are required to document in their QI programs that they are monitoring the range of quality of care across services and all treatment modalities. This review of the range of care shall be carried out over multiple review periods and not only on a concurrent basis.

(e) At least four state-approved Performance Improvement Projects (PIPs) must be performed by each Managed Medical Assistance (MMA) plan and at least two PIPs must be performed by each Long-term care (LTC) plan. Each study/project conducted by a plan must include a statistically significant sample of Medicaid lives. For MMA plans, one project must focus on each of the following topics:
- Improving prenatal care and well child visits in the first 15 months;
- Preventative dental care for children;
- An administrative PIP approved by the Agency; and
- Population health issues within a specific geographic area.
For the LTC plans, the projects must focus on:

- Medication Review; and
- A non-clinical PIP proposed by the plan and approved by the Agency.

The plans are required to provide notification to the state prior to implementation. The notification shall include the general description, justification, and methodology for each project and document the potential for meaningful improvement. The plans are required to report annually to the state. The report shall include the current status of the project including, but not limited to, goals, anticipated outcomes, and ongoing interventions. Each project shall have been through the plan’s quality process, including reporting and assessments by the quality committee and reporting to the board of directors.

Pursuant to 42 CFR 438.330, the state requires the projects to focus on clinical care and non-clinical areas (i.e. health services delivery). These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. CMS, in consultation with states and other stakeholders, may specify performance measures and topics for performance improvement projects. If CMS specifies performance improvement projects, the plan will participate and this will count towards the state-approved quality-of-care projects. Each individual CMS project can be counted as one of the state-approved quality of care projects. The quality-of-care projects used to measure performance improvement projects shall include diagrams (e.g., algorithms and/or flow charts) for monitoring and shall:

1. Target specific conditions and specific health service delivery issues for focused individual practitioner and system-wide monitoring and evaluation;
2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions;
3. Use appropriate quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered;
4. Implement system interventions to achieve improvement in quality;
5. Evaluate the effectiveness of the interventions;
6. Provide sufficient information to plan and initiate activities for increasing or sustaining improvement;
7. Monitor the quality and appropriateness of care furnished to enrollees with special health care needs;
8. Reflect the population served in terms of age groups, disease categories, and special risk status;
9. Ensure that appropriate health professionals analyze data;
10. Ensure that multi-disciplinary teams will address system issues;

11. Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal or benchmark;

12. Identify and use quality indicators that are measurable and objective;

13. Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis; and

14. Maintain a system for tracking issues over time to ensure that actions for improvement are effective.

The state requires the plan’s quality improvement information to be used in such processes as credentialing, contracting, and annual performance ratings. The state requires the plans to coordinate with other performance monitoring activities, including utilization management, risk management, and resolution and monitoring of member grievances. The state requires the plans to establish a link between other management activities such as network changes, benefits redesign, medical management systems (e.g., precertification), practice feedback to physicians, patient education, and member services.

The state requires the plans’ quality improvement programs to have a peer review component with the authority to review practice methods and patterns of individual physicians and other health care professionals, morbidity/mortality, and all grievances related to medical treatment; evaluate the appropriateness of care rendered by professionals; implement corrective action when deemed necessary; develop policy recommendations to maintain or enhance the quality of care provided to Medicaid enrollees; conduct a review process which includes the appropriateness of diagnosis and subsequent treatment, maintenance of medical records requirements, adherence to standards generally accepted by professional group peers, and the process and outcome of care; maintain written minutes of the meetings; receive all written and oral allegations of inappropriate or aberrant service; and educate recipients and staff on the role of the peer review authority and the process to advise the authority of situations or problems.

(f) The state requires the plans to collect data on patient outcome performance measures, as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) or otherwise defined by the state and to report the results of the measures to the state annually. The state may add or remove reporting requirements with 30-days advance notice.

The state requires the plans to submit their performance measure data and a certification by a state-approved, NCQA-certified independent auditor that the performance measure data reported for the previous calendar year have been fairly and accurately presented.

(g) The managed care plans conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The plans use the results of the annual member satisfaction survey to develop and implement plan-wide activities designed to improve member satisfaction. The state reviews the CAHPS survey
results and if there are any deficiencies, a corrective action plan is required within two months of the request from the state. The managed care plans report CAHPS survey results to the Agency by July 1 of each contract year.

The references to the contract provision incorporating this requirement can be found in Table 31.

![Table 31](https://example.com/table31.jpg)

**Table 31**

*Performance Improvement Projects*

42 CFR 438.330(d)

<table>
<thead>
<tr>
<th>Plan Type</th>
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<tr>
<td>Dental Program</td>
<td>Attachment II, Section IX, C.</td>
</tr>
</tbody>
</table>

3. Health Information Systems

The state requires the plans to comply with all the reporting requirements established by the state and specified in the plan’s contract. The plans are responsible for assuring the accuracy, completeness, and timely submission of each report. Deadlines for report submission referred to in the plan’s contract specify the actual time of receipt at the state, not the date the file was postmarked or transmitted. Before October 1 of each contract year, the plans are required to deliver to the state certifications by a State of Florida approved independent auditor that the Child Health Check Up screening rate reports have been fairly and accurately presented. In addition, by July 1, the plans are required to deliver to the state a certification by a State of Florida approved independent auditor that the quality indicator data reported for the previous calendar year have been fairly and accurately presented. The state furnishes the plans with the appropriate reporting formats, instructions, submission timetables and technical assistance as required.

The state requires certification of data as provided in 42 CFR 438.606. The data that must be certified include, but are not limited to, enrollment information, encounter data, and other information required by the state. The state reserves the right to modify the reporting requirements to which the plans must adhere but will allow the plans 90 calendar days to complete the implementation, unless otherwise required by law. The state provides the plans written notification of modified reporting requirements. Failure of the plan to submit required reports accurately and within the time frames specified in the plan’s contract may result in sanctions being levied.
Health information systems requirements specified in the MCO and PAHP contracts are outlined below.

(a) General Provisions

1. **Systems Functions.** The plans are required to have Information management processes and Information Systems (hereafter referred to as Systems) that enable the plan to meet state and federal reporting requirements and other contract requirements and that are in compliance with the contract and all applicable state and federal laws, rules and regulations including HIPAA.

2. **Systems Capacity.** The plans’ Systems are required to possess capacity sufficient to handle the workload projected for the begin date of operations and that will be scalable and flexible so they can be adapted as needed, within negotiated timeframes, in response to changes in contract requirements, increases in enrollment estimates, etc.

3. **E-Mail System.** The plans are required to provide a continuously available electronic mail communication link (E-mail system) with the state. This system shall be available from the workstations of the designated plan contacts and capable of attaching and sending documents created using software products other than the plan’s systems, including the state’s currently installed version of Microsoft Office and any subsequent upgrades as adopted.

4. **Participation in Information Systems Work Groups/Committees.** The state requires the plans to meet, as requested by the state, to coordinate activities and develop cohesive systems strategies across vendors and agencies.

5. **Connectivity to the Agency/State Network and Systems.** The plans are responsible for establishing connectivity to the state’s wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable state policies, standards and guidelines.

(b) Data and Document Management Requirements

1. **Adherence to Data and Document Management Standards.**
   a. The state requires the plans’ systems to conform to the standard transaction code sets specified in the contract.
   b. The state requires the plans’ systems to conform to HIPAA standards for data and document management that are currently under development within 120 calendar days of the standards’ effective date or, if earlier, the date stipulated by CMS or the state.
   c. The state requires the plans to partner with the state in the management of standard transaction code sets specific to the state. Furthermore, the plans are required to partner with the state in the development and implementation planning of future standard code sets not specific to HIPAA or other federal efforts and shall conform to these standards as stipulated in the plan to implement the standards.

2. **Data Model and Accessibility.** The state requires the plans’ systems to be Structured Query Language (SQL) and/or Open Database Connectivity (ODBC) compliant;
alternatively, managed care plans’ systems shall employ a relational data model in the architecture of their databases in addition to a relational database management system (RDBMS) to operate and maintain them.

3. **Data and Document Relationships.** The state requires the plans’ systems to house indexed images of documents used by enrollees and providers to transact with the plan in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain data.

4. **Information Retention.** The state requires the information in plans’ systems to be maintained in electronic form for three years in live systems and, for audit and reporting purposes, for seven years in live and/or archival systems.

5. **Information Ownership.** All Information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of the contract, is owned by the state. The plans are expressly prohibited from sharing or publishing the state information and reports without the prior written consent of the state. In the event of a dispute regarding the sharing or publishing of information and reports, the state’s decision on this matter shall be final and not subject to change.

(c) **System and Data Integration Requirements**

1. **Adherence to Standards for Data Exchange.**
   a. The plan’s systems are required to be able to transmit, receive and process data in HIPAA-compliant formats that are in use as of the plan’s contract execution date; these formats are detailed in plan’s contract.
   b. The plan’s Systems are required to be capable of transmitting, receiving and processing data in the state-specific formats and/or methods that are in use on the plan’s contract execution date, as specified in plan’s contract.
   c. The plan’s systems are required to conform to future federal and/or state specific standards for data exchange within 120 calendar days of the standard’s effective date or, if earlier, the date stipulated by CMS or the state. The plans are required to partner with the state in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. The plans are required to conform to these standards as stipulated in the plan to implement such standards.

2. **HIPAA Compliance Checker.**

All HIPAA-conforming exchanges of data between the state and the plans are subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker application.

3. **Data and Report Validity and Completeness.**

The plans are required to institute processes to ensure the validity and completeness of the data, including reports, the plan submits to the state. At the state’s discretion,
the state will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Enrollee ID, date of service, assigned Medicaid Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of claim processing, and (if and when applicable) date of claim payment. Control totals shall also be reviewed and verified.

4. State/Agency Website/Portal Integration.

Where deemed that the plan’s Web presence will be incorporated to any degree in the state’s or the state’s Web presence (also known as Portal), the plans are required to conform to any applicable state standard for Website structure, coding and presentation.

5. Connectivity to and Compatibility/Interoperability with Agency Systems and IT Infrastructure.

The state requires the plans to be responsible for establishing connectivity to the state’s wide area data communications network, and the relevant information systems attached to this network, in accordance with all applicable state policies, standards and guidelines.

6. Functional Redundancy with FMMIS.

The state requires the plans to be able to transmit and receive transaction data to and from FMMIS as required for the appropriate processing of claims and any other transaction that could be performed by either System.

7. Data Exchange in Support of the Agency’s Program Integrity and Compliance Functions.

The state requires the plans’ system(s) to be capable of generating files in the prescribed formats for upload into Agency systems used specifically for program integrity and compliance purposes.

8. Address Standardization.

The state requires the plan’s system(s) to possess mailing address standardization functionality in accordance with US Postal Service conventions.

9. Eligibility and Enrollment Data Exchange Requirements:
   a. The state requires the plans to receive, process, and update enrollment files sent daily by the Agency or its Agent;
   b. The state requires the plans to update their eligibility/enrollment databases within twenty-four (24) hours of receipt of said files;
   c. The state requires the plans to transmit to the state or its agent, in a periodicity schedule, format and data exchange method to be determined by the state, specific data it may garner from a plan’s enrollee including third party liability data; and
   d. The state requires the plans to be capable of uniquely identifying a distinct Medicaid recipient across multiple systems within its span of control.

(d) Systems Availability, Performance and Problem Management Requirements

The state requires the plans to ensure that critical systems functions available to plan enrollees and providers – functions that if unavailable would have an immediate detrimental impact on enrollees and providers – are available 24 hours a day, seven days a week, except during periods of scheduled System unavailability agreed upon by the state and the plan. Unavailability caused by events outside of a plan’s span of control is outside of the scope of this requirement.

2. Availability of Data Exchange Functions.

The state requires the plans to ensure that the systems and processes within its span of control associated with its data exchanges with the state and/or its Agent(s) are available and operational according to specifications and the data exchange schedule.

3. Availability of Other Systems Functions.

The state requires the plans to ensure that at a minimum, all other system functions and Information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., EST or EDT as appropriate, Monday through Friday.

4. Problem Notification.

   a. Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in the systems, including any problems impacting scheduled exchanges of data between the plan and the state and/or its Agent(s), the plan must notify the applicable state staff via phone, fax and/or electronic mail within 15 minutes of such discovery. In their notification, the plans are required to explain in detail the impact to critical path processes such as enrollment management and claims submission processes.

   b. The state requires the plans to provide to appropriate state staff information on system unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

5. Recovery from Unscheduled System Unavailability.

Unscheduled system unavailability caused by the failure of systems and telecommunications technologies within the plan’s span of control will be resolved, and the restoration of services implemented, within eight hours of the official declaration of system unavailability.


The plans are not responsible for the availability and performance of systems and information technology infrastructure technologies outside of the plan’s span of control.


Full written documentation that includes a corrective action plan, that describes how problems with critical Systems functions will be prevented from occurring again, are required to be delivered within five (5) business days of the problem’s occurrence.
8. Business Continuity-Disaster Recovery (BC-DR) Plan

a. Regardless of the architecture of its systems, the plans are required to develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan that is reviewed and prior-approved by the state.

b. At a minimum the plan’s BC-DR plan shall address the following scenarios: (1) the central computer installation and resident software are destroyed or damaged, (2) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (3) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, (4) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability.

c. The state requires the plans to periodically, but no less than annually, perform comprehensive tests of its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the state that it can restore System functions per the standards outlined elsewhere in contract.

d. In the event that the plan fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in the contract, the plans must submit to the state a corrective action plan in accordance with contract which describes how the failure will be resolved. The corrective action plan shall be delivered within ten business days of the conclusion of the test.

(e) System Testing and Change Management Requirements

1. Notification and Discussion of Potential System Changes.

The state requires the plans to notify the applicable state staff person of the following changes to Systems within its span of control within at least 90 calendar days of the projected date of the change; if so directed by the state, the plan is required to discuss the proposed change with the applicable state staff: (1) software release updates of core transaction Systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management; (2) conversions of core transaction management Systems.

2. Response to Agency Reports of Systems Problems not Resulting in System Unavailability.

The state requires the plans to respond to state reports of System problems not resulting in System unavailability according to the following timeframes:

a. Within seven calendar days of receipt, the Health Plan shall respond in writing to notices of system problems.

b. Within 20 calendar days, the correction will be made or a requirements analysis and specifications document will be due.
c. The plan will correct the deficiency by an effective date to be determined by the state.

3. Valid Window for Certain System Changes.

Unless otherwise agreed to in advance by the state as part of the activities described in the contract, scheduled system unavailability to perform system maintenance, repair and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.

4. Testing

  d. The state requires the plans to work with the state pertaining to any testing initiative as required by the state.

  e. The state requires the plans to provide sufficient system access to allow the state and/or independent testing of the plan’s systems during and subsequent to readiness review.

(f) Information Systems Documentation Requirements

1. Types of Documentation.

The state requires the plans to develop, prepare, print, maintain, produce, and distribute distinct System Process and Procedure Manuals, User Manuals and Quick/Reference Guides, and any updates thereafter, for the state and other applicable state staff.

2. Content of System Process and Procedure Manuals.

The state requires the plans to ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

3. Content of System User Manuals.

The System user manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.


    a. When a system change is subject to state sign off, the plans are required to draft revisions to the appropriate manuals prior to state sign off of the change.

    b. Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten business days of the update taking effect.

5. Availability of/Access to Documentation.

All of the aforementioned manuals and reference guides shall be available in printed form and/or on-line. If so prescribed, the manuals will be published in accordance with the appropriate state standard.

(g) Reporting Requirements - Specific to Information Management and Systems Functions and Capabilities and Technological Capabilities
1. Reporting Requirements.

The state requires the plans to submit a monthly Systems Availability and Performance Report to the state as described in contract.

2. Reporting Capabilities.

The state requires the plans to provide systems-based capabilities to authorized state personnel, on a secure and read-only basis, to access data that can be used in ad hoc reports.

(h) Other Requirements

Community Health Record/Electronic Medical Record and Related Efforts

a. At such time that the state requires, the plans are required to participate and cooperate with the state to implement, within a reasonable timeframe, secure, Web-accessible Community Health Records for enrollees.

b. The design of the vehicle(s) for accessing the Community Health Record, the health record format and design shall comply with all HIPAA and related regulations.

c. The state requires the plans to also cooperate with the state in the continuing development of the state's health care data site: www.FloridaHealthFinder.gov

(i) Compliance with Standard Coding Schemes

1. Compliance with HIPAA-Based Code Sets. A plan's system that is required to or otherwise contains the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed:

   a. Logical Observation Identifier Names and Codes (LOINC)
   b. Health Care Financing Administration Common Procedural Coding System (HCPCS)
   c. Home Infusion EDI Coalition (HIEC) Product Codes
   d. National Drug Code (NDC)
   e. National Council for Prescription Drug Programs (NCPDP)
   f. International Classification of Diseases (ICD-9)
   g. Diagnosis Related Group (DRG)
   h. Claim Adjustment Reason Codes
   i. Remittance Remarks Codes

2. Compliance with Other Code Sets.

A plan system that is required to or otherwise contains the applicable data type shall conform to the following non-HIPAA-based standard code sets:

a. As described in all Medicaid Provider Reimbursement Handbooks, for all "Covered Entities", as defined under the HIPAA, and which submit transactions in paper format (non-electronic format).

b. As described in all Medicaid Provider Reimbursement Handbooks for all "Non-covered Entities", as defined under the HIPAA.
(j) Data Exchange and Formats and Methods Applicable to Health Plans

1. HIPAA-Based Formatting Standards.

MCO and PAHP Systems are required to conform to the following HIPAA-compliant standards for information exchange effective the first day of operations in the applicable service region:

**Batch transaction types**
- ASC X12N 834 Enrollment and Audit Transaction
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- ASC X12N 837D Dental Claim/Encounter Transaction
- NCPDP 1.1 Pharmacy Claim/Encounter Transaction

**Online transaction types**
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 278/279 Utilization Review Inquiry/Response - NCPDP 5.1 Pharmacy Claim/Encounter Transaction


The plan and the state and/or its agent(s) shall make predominant use of Secure File Transfer Protocol (SFTP) and Electronic Data Interchange (EDI) in their exchanges of data.

3. Agency-Based Formatting Standards and Methods.

Plan Systems are required to exchange the following data with the state and/or its agent(s) in a format to be jointly agreed upon by the plan and the state:

a. Provider network data
b. Case management fees
c. Administrative payments

The references to the contract provision incorporating these requirements can be found in Table 32.
Table 32
Health Information Systems

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section X; Exhibit II-A; Exhibit II-B</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section X</td>
</tr>
</tbody>
</table>

4. Table 33 provides a summary list of the reports required by the state for contracts operated under the 1115 Demonstration Waiver.

5. The SMMC Report Guide containing detailed instructions for these reports can be accessed at: http://ahca.myflorida.com/Medicaid/statewide_mc/report_guide_2018-12-01.shtml

Table 33
Medicaid Managed Care Required Reports

<table>
<thead>
<tr>
<th>Contract Section</th>
<th>Report Name</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section XII and XVI</td>
<td>Achieved Savings Rebate Financial Reports</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Section XII and XVI</td>
<td>Administrative Subcontractors and Affiliates Report</td>
<td>Quarterly, within fifteen (15) calendar days after the end of the reporting quarter.</td>
</tr>
<tr>
<td>Section VIII and XVI</td>
<td>Annual Fraud and Abuse Activity Report</td>
<td>Annually, by September 1st.</td>
</tr>
<tr>
<td>Section X and XVI</td>
<td>Audited Annual and Unaudited Quarterly Financial Reports</td>
<td>Audited - Annually, on or before April 1 following the end of each reporting calendar year;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unaudited - Quarterly, within 45 calendar days after the end of each reporting quarter.</td>
</tr>
<tr>
<td>Contract Section</td>
<td>Report Name</td>
<td>Frequency</td>
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</tr>
<tr>
<td>Section VII and XVI</td>
<td>Code 15 Report</td>
<td>Variable, within fifteen (15) calendar days after the Managed Care Plan received information about the incident.</td>
</tr>
<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>CHCUP (CMS-416) &amp; FL 80% Screening</td>
<td>Audited - Annually, on or before July 1 following the end of the reporting federal fiscal year (October 1 through September 30).</td>
</tr>
<tr>
<td>Section VII and XVI</td>
<td>Critical Incident Report</td>
<td>Variable, immediately upon occurrence and no later than twenty-four (24) hours after detection of notification.</td>
</tr>
<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>Hernandez Settlement Ombudsman Log</td>
<td>Quarterly, fifteen (15) calendar days after the end of the reporting quarter.</td>
</tr>
<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>Hernandez Settlement Agreement Survey</td>
<td>Annually, on or before August 1 of each year.</td>
</tr>
<tr>
<td>Section VII and XVI</td>
<td>Critical Incident Summary Report</td>
<td>Monthly, by the fifteenth (15th) calendar day of the month following the reporting month and rolled up for quarter and year.</td>
</tr>
<tr>
<td>Section IV and XVI</td>
<td>Enrollee Complaints, Grievances, and Appeals Report</td>
<td>Monthly, within fifteen (15) calendar days after the end of the reporting month.</td>
</tr>
<tr>
<td>Section IV. D.5.h. and XVI</td>
<td>Enrollee Help Line Statistics Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Contract Section</td>
<td>Report Name</td>
<td>Frequency</td>
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<td>------------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Section IV. D.5.g. and XVI</td>
<td>Marketing Agent Termination Report</td>
<td>Variable, two weeks prior to any outreach or marketing activities to be performed by the marketing agent (variable); Quarterly, within forty-five (45) calendar days after the end of the reporting quarter.</td>
</tr>
<tr>
<td>Section I.A; Section III, D.14.</td>
<td>Market/Educational Events Report</td>
<td>Monthly, no later than the twentieth (20\textsuperscript{th}) calendar day of the month prior to the event month; Variable, amendments to the report are due no later than two weeks prior to the event.</td>
</tr>
<tr>
<td>Section VII; Exhibit II-B, Section V and VII; Exhibit II-A, Section V</td>
<td>Performance Measures Report – LTC and MMA</td>
<td>Annually, by July 1, for the prior calendar year.</td>
</tr>
<tr>
<td>Section VI and XVI</td>
<td>Provider Complaint Report</td>
<td>Monthly, within fifteen (15) calendar days after the end of the reporting month.</td>
</tr>
<tr>
<td>Section VI and XVI</td>
<td>Provider Network File</td>
<td>Weekly, on Thursday by 5:00 p.m. EST.</td>
</tr>
<tr>
<td>Section VI and XVI</td>
<td>Provider Termination and New Provider Notification Report</td>
<td>Weekly, on Wednesday by 5:00 p.m. EST.</td>
</tr>
<tr>
<td>Section VIII and XVI</td>
<td>Quarterly Fraud &amp; Abuse Activity Report</td>
<td>Quarterly, within fifteen (15) calendar days after the end of the quarter being reported.</td>
</tr>
<tr>
<td>Section VIII and XVI</td>
<td>Suspected/Confirmed Fraud and Abuse Reporting</td>
<td>Variable, within fifteen (15) calendar days of detection.</td>
</tr>
<tr>
<td>Contract Section</td>
<td>Contract Section</td>
<td>Contract Section</td>
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</tr>
<tr>
<td>Exhibit II-B, Section V and XVI</td>
<td>Case Management File Audit Report</td>
<td>Quarterly, within 30 calendar days after the end of the reporting quarter.</td>
</tr>
<tr>
<td></td>
<td>Case Management Monitoring and Evaluation Report</td>
<td>Quarterly, within 30 calendar days after the end of the quarter;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual roll-up, within 30 calendar days after the end of the fourth (4th) quarter.</td>
</tr>
<tr>
<td>Exhibit II-B, Section V and XVI</td>
<td>Case Manager Caseload Report</td>
<td>Monthly, within fifteen (15) calendar days after the end of the reporting month.</td>
</tr>
<tr>
<td></td>
<td>Denial, Reduction, Suspension or Termination of Services Report</td>
<td>Monthly, within fifteen (15) calendar days after the end of the reporting month.</td>
</tr>
<tr>
<td>Exhibit II-B, Section V and XVI</td>
<td>Enrollee Roster and Facility Residence Report</td>
<td>Monthly, within fifteen (15) calendar days after the beginning of the reporting month.</td>
</tr>
<tr>
<td>Section VIII and XVI</td>
<td>Claims Aging Report &amp; Supplemental Filing Report</td>
<td>Quarterly, within forty-five (45) calendar days after the end of the reporting quarter;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capitated Managed Care Plans, optional Supplemental Filing Report is due within one hundred-five (105) calendar days after the end of each reporting quarter.</td>
</tr>
</tbody>
</table>
Table 33  
Medicaid Managed Care Required Reports

<table>
<thead>
<tr>
<th>Contract Section</th>
<th>Report Name</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibit II-B, Section V and XVI</td>
<td>Missed Services Report</td>
<td>Monthly, within thirty (30) calendar days after the end of the reporting month.</td>
</tr>
<tr>
<td>Section X and XVI</td>
<td>Audited Annual and Unaudited Quarterly Financial Reports</td>
<td>Audited – Annually, Unaudited – Quarterly,</td>
</tr>
<tr>
<td>Exhibit II-B, Section V and XVI</td>
<td>Participant Direction Option (PDO) Roster Report</td>
<td>Monthly, within fifteen (15) calendar days after the end of the reporting month.</td>
</tr>
<tr>
<td>Exhibit II-B, Section V and XVI</td>
<td>Patient Responsibility Report</td>
<td>Annually, by October 1, for the prior Contract year.</td>
</tr>
<tr>
<td>Exhibit II-A, Section VI and XVI</td>
<td>Additional Network Adequacy Standards Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>ACA PCP Payment Increase Report</td>
<td>Quarterly, by the last day of the month after the end of the reporting quarter.</td>
</tr>
<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>Customized Benefit Notification Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Exhibit II-A, Section VI and XVI</td>
<td>Electronic Health Records Standards Report</td>
<td>Quarterly</td>
</tr>
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<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>ER Visits for Enrollees without PCP Appointment Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>Healthy Behaviors Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>Patient Centered Medical Home (PCMH) Providers Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Exhibit II-A, Section V and XVI</td>
<td>PCP Appointment Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Exhibit II-A, Section VI and XVI</td>
<td>Timely Access/PCP Wait Times Report</td>
<td>Annually, on or before February 1, following the reported calendar year.</td>
</tr>
</tbody>
</table>

### A. Detailed information related to the Quality Measurement and Improvement Standards

1. **A Description of the Methods and Timeframes to Assess the Quality and Appropriateness of Care and Services to all Medicaid Enrollees.**

   The state requires the plans to implement mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. The plans are required to have mechanisms for all enrollees that include evaluation of health risk assessments, claims data, and, if available CPT/ICD-10 codes. The plans are required to implement a process for receiving and considering provider and enrollee input. In addition, the state requires the plans to contact each new member at least two times, if necessary, within 90 calendar days of enrollment, to urge scheduling of an initial appointment with the primary care provider for the purpose of a health risk assessment.

   The references to the contract provision incorporating this requirement can be found in Table 34.
Table 34
Assessment of the Quality & Appropriateness of Care and Services for Enrollees with Special Health Care Needs
42 CFR 438.208(c)(2)(3)

<table>
<thead>
<tr>
<th>Plan Type</th>
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<tr>
<td>Dental Program</td>
<td>Attachment II, Section IX, A. 3.</td>
</tr>
</tbody>
</table>

2. An Identification of the Populations Florida Considers when Determining Individuals with Special Health Care Needs.

The state uses the following population groups that were identified in the "Report to Congress – Safeguards for Individuals with Special Health Care Needs Enrolled in Medicaid Managed Care" dated November 6, 2000.

- Children with special health care needs;
- Children in foster care;
- Individuals with serious and persistent mental illness and/or substance abuse;
- Individuals who are homeless;
- Older adults with disabilities; and
- Non-elderly adults who are disabled or chronically ill with physical or mental disabilities.

To further define children with special health care needs, the state uses the CMS functional definition of children with special health care needs as stated in the January 19, 2001, State Medicaid Director letter, SMDL #01-012:

- Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI);
- Eligible under section 1902(e)(3) of the Social Security Act and are an optional Medicaid eligibility group (also known as “Katie Beckett” children) who require a level of care provided in institutions but reside in the community;
- In foster care or other out-of-home placement;
- Receiving foster care or adoption assistance; and
- Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501 (a)(1)(D) of Title V, as defined by the State in terms of either program participant or special health care needs.

3. Florida standards for the identification and assessment of individuals with special health care needs
The plans must have mechanisms that include evaluation of health risk assessments, claims data, and, if available CPT/ICD-9 codes for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. Additionally, the plans are required to implement a process for receiving and considering provider and enrollee input.

The references to the contract provision, which incorporates these requirements, is below in Table 35.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Program</td>
<td>Attachment II, Section IX. A.3; Exhibit II-A, E.7. c. and G.2.b</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section IX. A.3; Exhibit II-A, E.7. c. and G.2.b</td>
</tr>
</tbody>
</table>

4. Florida’s Procedures to Separately Assess the Quality and Appropriateness of Care and Services Furnished to all Medicaid Managed Care Enrollees and to Individuals with Special Health Care Needs

Prior to contracting with MCOs and PAHPs, the state conducts on-site surveys to document the plan’s capacity to assess the quality and appropriateness of care and services to Medicaid enrollees and individuals with special health care needs. The state conducts annual on-site quality of care surveys and desk reviews to ensure the plan maintains compliance with the plan’s contract including all applicable federal and state quality measurement and improvement regulations. The state quarterly monitors MCOs and PAHPs, which have been approved to provide services to Medicaid-eligible children with special health care needs as specified in s. 409.9126, Florida Statutes, each plan based on the plan’s provider network capacity to serve children with special health care needs. The state also utilizes the required health information system reports specified in each plan’s contract to monitor and assess the quality and appropriateness of care and services furnished by the plans to Medicaid enrollees and to individuals with special health care needs.

**MCO/PAHP Contractual Compliance**

The state conducts desk reviews and on-site surveys to document the plan’s capacity to comply with the state-established standards for access to care, structure and operations, and quality measurement and improvement. The state conducts quality of care surveys to ensure the MCOs and PAHPs maintain compliance with the plan’s contract including all applicable federal and state access to care, structure and
operations, and quality measurement and improvement requirements. The state regularly monitors the MCOs and PAHPs through desk reviews.

The references to the contract provision, which incorporates these requirements, is below in Table 36.

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Contract Provision</th>
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<tbody>
<tr>
<td><strong>Managed Care Organizations</strong></td>
<td></td>
</tr>
<tr>
<td>MMA and LTC Assistance Program</td>
<td>Attachment II, Section IX, A. and F; Exhibit II-A, Section IX. A.</td>
</tr>
<tr>
<td><strong>Prepaid Ambulatory Health Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Dental Program</td>
<td>Attachment II, Section IX, A, and F.</td>
</tr>
</tbody>
</table>

**Intermediate Sanctions**

The MCO and PAHP intermediate sanctions are designed to address identified quality of care problems in support of the state’s quality strategy and these sanctions meet, at a minimum, the requirements specified in 42 CFR 438 Subpart I. In accordance with section 4707 of the Balanced Budget Act of 1997, and section 409.912, F.S., the state may impose any of the following sanctions against the plan if the state determines that the plan has violated any provision of its contract, or the applicable statutes or rules governing the MCO or PAHP:

a. Suspension of the plan’s voluntary enrollments and participation in the assignment process for Medicaid enrollment.

b. Suspension or revocation of payments to the plan for Medicaid enrollees enrolled during the sanction period. If the plan has violated the contract, the state may order the plan to reimburse the complainant for out-of-pocket medically necessary expenses incurred or order the plan to pay non-network plan providers who provide medically necessary services.

c. Suspension of all marketing activities to Medicaid enrollees.

d. Imposition of a fine for violation of the contract with the state, pursuant to section 409.912, F.S. With respect to any nonwillful violation, such fine shall not exceed $2,500 per violation. In no event shall such fine exceed an aggregate amount of $10,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of section 409.912, F.S., or the contract with the state, the state may impose a fine upon the entity in an amount not to exceed $20,000 for each such violation. In no event shall such fine exceed an aggregate amount of $100,000 for all knowing and willful violations arising out of the same action.
e. Termination pursuant to paragraph III.B. (3) of the state’s core contract and the section on termination procedures, if the plan fails to carry out substantive terms of its contract or fails to meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Social Security Act. After the state notifies the plan that it intends to terminate the contract, the state may give the plan’s enrollees written notice of the state’s intent to terminate the contract and allow the enrollees to disenroll immediately without cause.

f. The state may impose intermediate sanctions in accordance with 42 CFR 438.702, including:

1. Civil monetary penalties in the amounts specified in section 409.912, F.S.
2. Appointment of temporary management for the plan. Rules for temporary management pursuant to 42 CFR 438.706 are as follows:
   a. The state may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that—
      i. There is continued egregious behavior by the plan, including but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act; or
      ii. There is substantial risk to enrollees’ health; or
   b. The sanction is necessary to ensure the health of the plan’s enrollees -
      i. While improvements are made to remedy violations under 42 CFR 438.700; or
      ii. Until there is an orderly termination or reorganization of the plan.
3. The state must impose temporary management (regardless of any other sanction that may be imposed) if it finds that a plan has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 CFR 438.706. The state must also grant enrollees the right to terminate enrollment without cause, as described in 42 CFR 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment.
4. The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.
5. The state may not terminate temporary management until it determines that the plan can ensure that the sanctioned behavior will not recur.
6. Granting enrollees the right to terminate enrollment without cause and notifying affected enrollees of their right to disenroll.
7. Suspension or limitation of all new enrollment, including default enrollment, after the effective date of the sanction.
8. Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
9. Denial of payments provided for under the contract for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with 42 CFR 438.730.
10. Before imposing any intermediate sanctions, the state must give the plan timely notice according to 42 CFR 438.710.

g. In accordance with section 409.912, F.S., if the plan’s Child Health Check-Up screening compliance rate is below 60 percent, it must submit to the state, and implement, a state accepted corrective action plan. If the plan does not meet the standard established in the corrective action plan during the time period indicated in
the corrective action plan, the state has the authority to impose sanctions in accordance with this section.

Unless the duration of a sanction is specified, a sanction shall remain in effect until the state is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

The references to the contract provision incorporating this requirement can be found in Table 37.

<table>
<thead>
<tr>
<th>Table 37</th>
<th>MCO Intermediate Sanctions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>42 CFR 438 Subpart I</td>
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<td>Plan Type</td>
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<td>Dental Program</td>
<td>Attachment II, Section XIII, A. and B.</td>
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</table>
APPENDIX IV

Quality Compliance Monitoring Reports

**Adverse and Critical Incident Report:** The purpose of this monthly report is to monitor all managed care plans’ adverse and critical incident reporting and management systems for adverse and critical incidents that negatively impact the health, safety or welfare of enrollees. This includes all service delivery settings applicable to enrollees.

**Appointment Wait Time Report:** The purpose of this quarterly report is to provide the Agency with confirmation of the managed care plans’ examination and regular review of a statistically valid sample of primary care providers (PCP), specialists, behavioral health providers, and dental offices’ average appointment wait times to ensure these provider offices are held accountable for contractually obligated standards for enrollees receiving MMA and dental benefits.

**Enhanced Care Coordination Report:** The purpose of this monthly report is for managed care plans to report on enhanced care coordination for enrollees under the age of twenty-one (21) years receiving skilled nursing facility (NF) or private duty nursing (PDN) services. The Agency monitors this report to ensure compliance and ensure additional services are not needed for an enrollee; if there are, the Agency works with the managed care plans to ensure enrollees receive the services needed.

**ER Visits for Enrollees without a PCP/PDP Appointment Report:** The purpose of this annual report is to provide the Agency with information regarding the number of emergency room visits by enrollees with MMA or Dental Plan benefits who have not had at least one appointment with their primary care provider (PCP) or primary dental provider (PDP) during the reporting year. The Agency is working to enhance this report for more timely identification of these enrollees to ensure managed care plans work with these enrollees to set them up with a PCP and/or PDP home in helping to prevent potentially preventable hospital events.

**Health Risk Assessment Report:** The purpose of this quarterly report is to monitor completion of health risk assessments (HRAs) within the specified timeframe of completion (within 60 days of enrollment), specifically for pregnant enrollees and enrollees with serious mental illness (SMI), diabetes, and/or asthma. This report allows the Agency to identify managed care plans’ compliance with targets they set for themselves in terms of completed HRAs for each high-risk population noted above.

**Inter-Rater Reliability Report:** The purpose of this quarterly report is to provide the Agency with information regarding the managed care plan’s quality assurance and quality improvement program. The managed care plan conducts inter-rater reliability (IRR) audits of at least 1% of service authorization decisions per reviewer (nurses, therapists, physicians, etc.). Each reviewer must maintain an 85% accuracy rate. The Agency reviews and monitors IRR rates to ensure compliance and imposes compliance actions if managed care plans do not meet the 85% accuracy rate.
Oral Health Risk Assessment Report: The purpose of this quarterly report is to monitor completion of oral health risk assessments within the specified timeframe of completion (within 60 days of enrollment), specifically for pregnant members, enrollees under the age of 21, and enrollees with a developmental disability diagnosis. This report allows the Agency to identify dental plans’ compliance with targets they set for themselves in terms of completed assessments for each population noted above.

PCP/PDP Appointment Report: The purpose of this annual report is to provide the Agency with information regarding the number of enrollees with MMA benefits who have not had an appointment with their primary care provider (PCP) or primary dental provider (PDP) within their first year of enrollment. The Agency is working to enhance this report for more timely identification of these enrollees to ensure managed care plans work with these enrollees to set them up with a PCP and/or PDP home in helping to prevent potentially preventable hospital events.

Residential Psychiatric Treatment Report: The purpose of this monthly report is to provide the Agency with information regarding enrollees under the age of twenty-one (21) years who are receiving residential psychiatric treatment in Statewide Inpatient Psychiatric Program (SIPP) or Therapeutic Group Care (TGC) placements. The Agency closely monitors this report to ensure enrollees are placed into a facility for treatment timely and coordinates closely with managed care plans on any enrollees that require further assistance.

Service Authorization Performance Outcome Report: The purpose of this monthly report is to provide the Agency with information regarding the managed care plans’ service authorization process, including service authorization volumes, service authorization denial data, and timeframes for service authorization decisions. The Agency monitors this report to identify trends in service authorizations specific to covered service types.

Case Management File Audit Report: The purpose of this quarterly report is to ensure that the managed care plan has an internal monitoring system in place for its case management program, and that enrollees receiving LTC services are receiving quality care.

Case Manager and Provider Training Report: The purpose of this annual report is to gather data on performance measures for the Centers for Medicare and Medicaid Services (CMS) on the following: the most recent date direct hire and contracted LTC case managers received abuse, neglect, and exploitation training and Alzheimer’s disease and dementia training; and whether Direct Service Providers that are mandated to report abuse, neglect, and exploitation have received appropriate training.

Case Manager Caseload Report: The purpose of this monthly report is to ensure that enrollees receiving LTC services are receiving quality case management services by monitoring the caseload requirements.

Critical Incident Report—Individual: The purpose of this report is to monitor LTC plans’ critical incident reporting and management systems for critical incidents that negatively impact the health, safety or welfare of LTC enrollees. This includes critical incidents in all service delivery settings applicable to enrollees. This report is due immediately upon occurrence and no later than twenty-four (24) hours after detection or notification.
Denial, Reduction, Termination, or Suspension of Services Report: The purpose of this monthly report is to monitor for trends in the amount and frequency that the managed care plan denies, reduces, terminates or suspends services, including both home and community-based and nursing facility services, for enrollees receiving LTC services and reviewed to ensure managed care plans submit the Notice of Adverse Benefit Determination letters in compliance with the timeframe specified in the contract.

Enrollee Roster and Facility Residence Report: The purpose of this monthly report is to provide information on the current physical location of each enrollee receiving LTC services. The report is used to track and trend the number of LTC enrollees transitioning into the community from a nursing facility and vice versa and may be used for disaster recovery planning and relief.

Missed Services Report: The purpose of this monthly report is to monitor all missed facility and non-facility services covered by the managed care plan for enrollees receiving LTC services for the previous month, in accordance with the Long-term Care Contract/Exhibit. It is used to trend the most frequently missed Home and Community Based services. If any services were missed due to the provider (e.g., provider no-show, provider cancellation), the Agency will follow up with the managed care plans to mitigate any care coordination issues.