

COMPREHENSIVE QUALITY STRATEGY 2017



TABLE of CONTENTS

Part I. Introduction and Overview.....1

Part II. CQS Priorities and Goals.....2

Part III. 2017 Update of Initiatives Supporting Goals.....5

(A) STATEWIDE MEDICAID MANAGED CARE PROGRAM.....5

(B) MOVING TOWARD VALUE-BASED PURCHASING - PHYSICIAN INCENTIVE PROGRAM.....11

(C) SUPPORTING POSITIVE BIRTH OUTCOMES for MEDICAID.....14

(D) ORAL HEALTH.....20

APPENDIX 1 - MANAGED CARE CONTRACT PROVISIONS.....27

APPENDIX 2 - MEASURING PLANS’ PERFORMANCE.....97

APPENDIX 3 - CROSSWALK BETWEEN CMS REQUIRED ELEMENTS and CQS REPORT.....122

APPENDIX 1 Managed Care Contract Provisions

List of Tables

Table 1 External Quality Review 27

Table 2 Delivery Network Requirements 29

Table 3 Direct Access to Women’s Health Specialist 30

Table 4 Second Opinion Requirement 30

Table 5 Outside the Network 31

Table 6 Coordination with Outside the Network Providers 32

Table 7 Provider Credentialing 33

Table 8 Timely Access to Care 34

Table 9 Cultural Considerations 35

Table 10 Documentation of Adequate Capacity & Services 36

Table 11 Sufficient Network of Providers 37

Table 12 On-going Source of Primary Care 37

Table 13 Coordination of Services 38

Table 14 Duplicative Services for Individuals with Special Health Care Needs 38

Table 15 Privacy Protection 39

Table 16 Additional Services for Individuals with Special Health Care Needs 40

Table 17 Coverage of Services 41

Table 18 Medically Necessary Services 42

Table 19 Service Authorization Policies & Procedures	45
Table 20 Appropriate Health Care Professional / Denial of Services.....	46
Table 21 Identification of Persons with Special Health Care Needs	48
Table 22 Treatment Plan Standard	49
Table 23 Provider Selection and Retention, Credentialing and Recredentialing, Nondiscrimination, and Excluded Providers.....	50
Table 24 Enrollee Information	53
Table 25 Confidentiality	54
Table 26 Enrollment & Disenrollment	60
Table 27 Grievance System	68
Table 28 Subcontracted Relationships & Delegation.....	69
Table 29 Practice Guidelines.....	71
Table 30 Quality Assessment & Performance Program	72
Table 31 Performance Improvement Projects.....	76
Table 32 Health Information Systems.....	86
Table 33 Medicaid Managed Care Required Reports	86
Table 34 Assessment of the Quality & Appropriateness of Care and Services.....	91
Table 35 Identification and Assessment of Individuals with Special Health Care Needs	92
Table 36 Monitoring and Evaluation.....	93
Table 37 MCO Intermediate Sanctions	96

COMPREHENSIVE QUALITY STRATEGY REPORT 2017

Part I. Introduction and Overview

As part of the mission of the Agency for Health Care Administration (Agency) to promote better health care for all Floridians, this Comprehensive Quality Strategy (CQS) documents priorities and goals that guide the design for delivery of Medicaid services in Florida via the Agency, its contracted health plans and their service providers, and programs that are not included in statewide managed care. Consistent with the Agency's primary focus on improving health quality while streamlining processes and providing transparency and accountability for all functions, the CQS outlines the Agency's priorities and goals for the Florida Medicaid program, includes methods and metrics for assessing program performance, describes performance improvement activities and results, and highlights achievements and opportunities for state fiscal year (SFY) 2016--17.

The CQS describes quality improvement strategies and major initiatives throughout the Florida Medicaid program, including those implemented by Medicaid health plans and their service providers. While the Florida Medicaid program has historically engaged in quality improvement initiatives for various components of the Medicaid program, this document presents an integrated quality strategy which forms a framework to guide improvement of the various elements of service delivery.

Stakeholders include, but are not limited to, all Medicaid recipients; other state 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; and the state's External Quality Review Organization. Regular meetings and communications with the health plans, enrollees, advocacy groups, other agencies and other stakeholders support these partnerships.

Priorities and goals are outlined in Part II of this document, and Part III provides interim updates of the activities and major initiatives currently under way to promote achievement of these goals.

Part II. CQS Priorities and Goals

The following schematic outlines five priorities for Florida Medicaid for SFY 2016--17. Related to each priority are specific, measurable goals to guide the program's quality initiatives. These efforts are designed to measurably improve the health outcomes of all Medicaid recipients in the most efficient, innovative and cost effective ways possible. Florida Medicaid also strives to provide high quality care to all enrollees, regardless of their race or ethnicity, sex, sexual identity, age, disability, socioeconomic state, and geographic location. The factors, known as health disparities, are considered in the development and implementation of all quality improvement and initiatives.

Florida Medicaid employs the quality cycle to make continuous improvements to its programs as the Statewide Medicaid Managed Care (SMMC) program matures. The Medicaid program continuously evaluates specific quality and cost metrics to inform changes to the program design, health plan contracts, and oversight processes. This phase presents an opportunity to promote several aims of both state and federal partners. The Centers for Medicare and Medicaid Services (CMS) listed the following priorities for all consumers in its 2016 CMS Quality Strategy¹:

- Make care safer by reducing harm caused in the delivery of care.
- Strengthen person and family engagement as partners in their care.
- Promote effective communication and coordination of care.
- Promote effective prevention and treatment of chronic disease.
- Work with communities to promote best practices of healthy living.
- Make care affordable.

Listed below the priorities and goals in the following schematic are specific quality assurance and improvement initiatives currently under way within Florida Medicaid. Many of these initiatives are inter-related and support and impact more than one priority and set of goals. Several important initiatives are described in detail in "modules" in Part III of this document. These modules will be updated to reflect current, ongoing activity within each quality initiative, to keep leadership informed of this activity, and to measure progress toward meeting the various CQS goals and priorities.

In addition, there are traditional "significant change" indicators that would prompt a review of the Comprehensive Quality Strategy (including gathering stakeholder input):

- A material change in the numbers, types, or timeframes of reporting;
- A pervasive pattern of quality deficiencies identified through analysis of the annual reporting data submitted by the MCOs and PIHPs, the quarterly grievance reports, the state's annual compliance on-site surveys and desk reviews, and the enrollee complaints filed with the state;
- Changes to quality standards resulting from regulatory authorities or legislation at the state or federal level; or
- A change in membership demographics or the provider network of 50 percent or greater within one year.
- A change in Medicaid funding.

¹ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf>

Meanwhile, the information contained in this 2017 update reflects a dynamic comprehensive strategy based on changes to the Florida Medicaid program with Statewide Medicaid Managed Care now fully implemented. As noted above, this new strategy focuses on specific priorities and goals identified by Florida Medicaid, and the quality initiatives underway to promote these. The modular format of this report facilitates contributions by multiple units within the Quality Bureau at Florida Medicaid, with frequent updates of current initiatives/modules, and the addition of new modules describing other initiatives. These updates will be submitted to CMS in a timely manner, and will be posted to the Agency's website.



Florida Medicaid Comprehensive Quality Strategy Summary

PRIORITIES:

Improved Health Outcomes	Simplified and streamlined service delivery to promote efficient, timely, appropriate use of health services	Support for person and family-centered care	Greater transparency and accountability to promote cost effectiveness and efficient administration	Improved care coordination via performance monitoring and communication
Focus on priority populations with needed, improved services	Reduce unnecessary ED visits, unplanned pregnancies, C-sections, hospital readmissions, inappropriate use of medications, etc. through prevention, planning, service accessibility	Improve health literacy to engage recipients, families, consumers in healthcare planning and service delivery	Promote a quality-focused, data-informed and continuous learning Agency	Promote clear communication among providers, plans, patients, families; promote care that is accessible, coordinated, co-located, optimal

GOALS:

CURRENT INITIATIVES SUPPORTING GOALS

<ul style="list-style-type: none"> Dental Services for Children, Adults Behavioral Health Programs Serious Mental Illness (SMI) Substance Abuse Disorders (SUD) Hemophilia Contracting Diabetes Management Prescribed Pediatric Extended Care (PPEC) Long-Term Care (LTC) HIV/AIDS Waivers for coverage of specialized services 	<ul style="list-style-type: none"> Medicaid Physician Incentive Program (MPIP) Single Preferred Drug List (PDL) Early Elective Deliveries (EED) Policy Long-Acting Reversible Contraceptives Initiatives (LARCs) Performance Improvement Projects: <ul style="list-style-type: none"> Prenatal Care Well Child Visits in First 15 Months Healthy Start Services Re-Design for Managed Medical Assistance (MMA) Family Planning Waiver 	<ul style="list-style-type: none"> Health Plan Consumer Report Cards Dental Consumer Engagement Patient Centered Medical Homes Healthy Behaviors Initiatives Early Intervention Services (EIS) Health Plan Consumer Forums Medical Care Advisory Committee (MCAC) Consumer Input 	<ul style="list-style-type: none"> Health Plan Performance Measure Reporting Requirements Health Plan Consumer Report Cards Health Plan Satisfaction Surveys (CAHPS) and Reporting Long-Term Care (LTC) Consumer Survey and Reporting MMA and LTC Program Independent Evaluations Encounter Claims Monitoring Business Intelligence Quarterly Reports Complaint Hub Reports Medicaid Data Visualization Series (Tableau Reports) 	<ul style="list-style-type: none"> Clinical Quality Monitoring Recipient and Provider Assistance Complaint Hub Quality PIP Teams Physical and Behavioral Health Integration Staterwide Inpatient Pediatric Psychiatric (SIPP) Care Coordination Inter-agency Child Services Coordination Care Coordination for Medically Complex Children
---	---	--	--	---

Part III. 2017 Update of Initiatives Supporting Goals

(A) *Statewide Medicaid Managed Care Program:*

The State of Florida Agency for Health Care Administration (Agency) operates a section 1115(a) research and demonstration waiver. That 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 Medicaid health plan to ensure improved communication, provision of appropriate services, and continuity of care.

Capitation rates for payments to the health plans are certified by actuaries, and recognize the various risk and cost factors associated with each enrollee's specific health conditions. Health plans have incentives to provide high quality, cost-effective care because they are at risk for any costs in excess of this payment, and because there are contractual adverse consequences for failing to meet specific quality metrics. The Agency's performance improvement strategy employs imposition of sanctions and liquidated damages, and the opportunity to earn incentives to drive continuous quality improvement.

There are two components to SMMC: The Long-term Care (LTC) Program and the Managed Medical Assistance (MMA) Program.

(1) The Long-term Care (LTC) 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 waiver,² which began operations in one region of the state on August 1, 2013, and was rolled out in all eleven regions by March 1, 2014. The Florida Statute outlined 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)). In order to facilitate successful transitions from the nursing facility to the community, LTC health plans develop and implement individualized person-centered care plans for every LTC enrollee, and case managers counsel enrollees about their options for transitioning to the community. To encourage integration between long-term care services and medical services in comprehensive plans, the Agency's Auto-Assignment Algorithm is designed to refer to the enrollee's existing managed care plan (MMA or LTC) and prioritize assignment to the managed care plan. Moreover, the contract specifies that the coordination of mixed services (services provided by both MMA and LTC) be integrated and coordinated by one case manager (LTC).

² 1915(b)(c) Long-term Care Managed Care Waiver, originally approved February 1, 2013 and renewed December 19, 2016

(2) Managed Medical Assistance (MMA) program:

Following a formal negotiation process designed to promote enhanced services and innovation in health care systems, in February 2014 the Agency executed contracts with 17 health plans for the MMA program. At this time the Agency also executed a contract with an MMA specialty plan serving recipients who are dually eligible for both Medicare and Medicaid and who have certain chronic conditions. In April 2014 the Agency executed an additional contract with an MMA specialty plan serving children with chronic conditions.

The health plans the Agency contracted with were selected through the state's competitive procurement process to ensure that enrollees receive 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.

As of November 2016, after several mergers, a total of 16 MMA plans remain in the Florida Medicaid program. Ten of these plans provide only MMA services, while six of the plans are Comprehensive LTC plans that provide both MMA and LTC services. One of the Comprehensive LTC plans includes a specialty plan for children in the Child Welfare system. In addition to the specialty plans for children in the Child Welfare System and for dual eligibles, there are also two MMA specialty plans for recipients with HIV/AIDS, and one MMA specialty plan for recipients with Serious Mental Illness (SMI).

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

- (a) 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;
- (b) Review and resolution of recipient complaints, grievances, and appeals as part of the rapid cycle response system;
- (c) Healthy Behaviors programs to encourage and reward members for engaging in actions to improve their personal health, for example, a medically-approved smoking cessation program, a medically-directed weight loss program, and a medically-approved alcohol or substance use recovery program;
- (d) Reporting of audited health plan quality metrics that are used by the Agency to produce web-based consumer report cards to encourage recipients' comparisons among the health plans available in their areas;
- (e) Promoting health plan accountability by imposing specific financial consequences for failure to meet quality, customer service and financial standards;

- (f) Performance improvement projects that target several key HEDIS³ 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;
- (g) Support consumer participation on Florida's Medical Care Advisory Committee (MCAC) and other forums; and
- (h) Annual independent validation of each health plan's encounter data.

The shift from multiple delivery systems to SMMC includes a greater emphasis on quality improvement and quality measurement. Prior to SMMC, there were discrete quality improvement activities for the various delivery systems. Much of the focus was on administrative processes. The SMMC program, through improved coordination of each member's services and service providers, allows an integrated, comprehensive quality strategy. The resulting person-centered approach deploys data-driven, focused, and systematic feedback to health plan contract managers and policy and clinical staff. The Agency's independent External Quality Review Organization (EQRO) provides technical assistance to health plans to support measureable improvement in their quality of service delivery and health outcomes for Medicaid recipients.

(3) Health Plan Performance Measures:

Plans were required to report on 42 performance measures for calendar year 2015 reporting. 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)⁴ (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 measures⁵ (e.g., the percentage of children who received at least one preventive dental service);
- CMS Medicaid Adult Core Set measures (e.g., the percentage of adults that were readmitted to the hospital within 30 days);
- State-defined measures (used for areas of focus for which no national benchmark measures are available) (e.g., the percentage of enrollees with HIV/AIDS that were seen by a doctor outside of the hospital);

³ 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).

⁴ 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.

⁵ 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.

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) surveys⁶; and
- Long-term Care Plan Enrollee Survey⁷.

Florida Medicaid requires each type of health plan to report specified performance measures that are relevant to the services it provides. For SMMC, the state has selected particular plan performance measures for the LTC plans and for the MMA plans. Specialty plans report additional measures that are relevant to the populations they serve. (For example, the Child Welfare Specialty Plan and the plan for children with chronic conditions do not report on the adult-only performance measures.) The state continues to work with its External Quality Review Organization (EQRO) 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 array of 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.

The Florida Medicaid program has historically evaluated and compared performance measure and survey data 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 Cards⁸, which are available to Medicaid enrollees for use in selecting a plan. The current consumer report cards include audited⁹ HEDIS performance measure results. CAHPS survey results are also posted online for consumers to view¹⁰. In addition, Florida Medicaid is currently collaborating with federal CMS to develop metrics for evaluating and comparing metrics for individual direct service providers or practice groups. Medicaid staff are soliciting input from health plans regarding relevant metrics the plans are using to monitor their participating providers.

⁶CAHPS surveys ask consumers 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 (AHRQ) and CAHPS surveys are included in HEDIS by NCQA. The Agency requires Managed Medical Assistance plans to contract with NCQA-certified CAHPS survey vendors to conduct their surveys each year. Additional details about this survey are included in Appendix 2 of the Comprehensive Quality Strategy.

⁷ LTC Plans are required to contract with an independent survey vendor to conduct a satisfaction and experiences with care survey of a sample of the plans' enrollees each year. Additional details about this survey are included in Appendix 2 of the Comprehensive Quality Strategy.

⁸ The Medicaid Health Plan Report Card is found at <http://www.floridahealthfinder.gov/HealthPlans/Default.aspx>.

⁹ 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 2 of the Comprehensive Quality Strategy.

¹⁰ At <http://www.floridahealthfinder.gov/HealthPlans/Default.aspx>

In addition to monitoring its health plans and external quality reviews of health plans, Florida Medicaid holds 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 research team at Florida State University and the MMA program by a team at the University of Florida.

(4) 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 the respective health plans' performance. Annual comparison of health plans' results to specific thresholds and national benchmarks (when available) documents the health plans' Florida Medicaid performance relative to each other and to national means and percentiles for other Medicaid programs around the nation. For example, the program's evaluation model requires SMMC health plans to achieve a minimum of 75th percentile goal as listed in the NCQA's National Means and Percentiles for Medicaid plans for all HEDIS measures. Please see Appendix B for a detailed description of the methodology for comparing health plans' quality metrics to specified benchmarks.

(5) How do these Metrics Drive Quality Improvement?

Publication of HEDIS, CAHPS and LTC Enrollee Survey results comparisons drive quality improvement by:

- Providing a means by which health plans can compare their performance and target areas in which improvement is needed;
- Giving consumers the tools to increase the market share for higher-performing health plans' by choosing the plans that best meet their needs;
- Providing a basis for calculation of liquidated damages, sanctions (which can include a moratorium on plan enrollment) 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 quality performance of Medicaid health plans in Florida to that of other states' Medicaid programs.

(6) Health Plan Contract Requirements for Targeted Performance Improvement Projects (PIPs):

Health plan contracts require them to implement validated Performance Improvement Projects (PIPs) for specific outcome targets. PIPs for fiscal year 2016-17 include projects targeted to increase the HEDIS measures related to prenatal care, postpartum care, and well-child visits to the health care provider within the first 15 months of life. These priorities reflect the importance of birth outcomes, as Medicaid provides coverage for over 60 percent of the births in Florida; and more than two million children in the state receive their health care through the Medicaid program.

Please see (section reference) for more information regarding Medicaid Quality PIP Teams that provide oversight and technical assistance for health plans in measurement, rapid cycle improvement, and increasing the effectiveness of their PIPs

(7) External Quality Review Organization (EQRO):

Pursuant to federal requirements related to quality review, the Agency contracts with Health Services Advisory Group, Inc. (HSAG) as its External Quality Review Organization (EQRO) vendor. Consistent with these federal requirements¹¹, the Agency's contract with HSAG includes the following eight categories of activities:

- Validation of health plans' Performance Improvement Projects (PIPs);
- 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 1 for a more detailed description of the activities of the required EQRO.

¹¹ External quality review is required by 42 CFR 438.350. External quality review activities are described in 42 CFR 438.358. The Centers for Medicare and Medicaid Services (CMS) have established external quality review protocols for each activity, which are available online at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>.

(B) Moving Toward Value-Based Purchasing: Florida Medicaid Medical Assistance Physician Incentive Program (MPIP):

(1) Background--Florida Requirement for a New Quality-Based Incentive for Physicians:

The statutory requirements for Statewide Medicaid Managed Care (SMMC) include provisions requiring health plans to increase compensation for physicians, to equal or exceed Medicare rates for similar services.¹² These payments are to be funded from savings realized through efficiencies in care coordination. Thus the health plans participating in Florida Medicaid are expected to coordinate care, manage chronic disease and prevent the need for higher-cost care on the premise that effective care management enables redirection of resources to increase compensation for qualifying physicians.

(2) Development of the MMA Physician Incentive Program:

(a) The Agency for Health Care Administration (the Agency) has taken this opportunity to implement a program providing quality-based incentive payments for physicians, to promote innovative systems of delivery of care that reward value over volume of care. Focusing first on pediatricians and OB/GYNs, the Agency solicited detailed input from each Medicaid health plan regarding the design of an incentive arrangement for qualifying physicians in the plans' networks. Each health plan was then given the option to adopt either the MPIP model defined by the Agency, or to establish its own unique program with Agency approval. Other physician types will be considered for inclusion in the MPIP program in the future.

(b) Florida Medicaid's MMA health plans made the first incentive payments to their qualified pediatricians and OB/GYNs on October 1, 2016. Every six months, providers who have met the qualifications for the incentive program can begin receiving enhanced payments.

(3) How Physicians Qualify for MPIP Payments—Elements of Quality and Access Standards:

(a) Designated Patient Centered Medicaid Home (PCMH). The Patient-Centered Medical Home (PCMH) is a model of care that emphasizes care coordination and communication to transform traditional primary care into patient-centered care. PCMHs inspire quality in care, cultivate more engaging patient relationships, and capture savings through expanded access and delivery options that align patient preferences with payer and provider capabilities. "A growing body of scientific evidence shows that PCMHs are saving money by reducing hospital and emergency department visits, mitigating health disparities, and improving patient outcomes"¹³

PCMH-recognized practices have been recognized for service delivery improvements, which typically lead to higher scores on certain process measures and utilization targets, as well as improvements in consumer satisfaction ratings.

(b) The Agency-defined MPIP incorporates PCMH recognition (by NCQA, AAAHC or the Joint Commission) as an indicator of the quality standards required for board-certified pediatric and OB/GYN clinics/providers to be eligible for MPIP payments. Some health plan-developed MPIPs also require the PCMH designation for pediatricians wishing to be qualified. In all, ten

¹² s. 409.967(2)(a), *Florida Statutes*.

¹³ <http://www.ncqa.org/programs/recognition/practices/pcmh-evidence>, December 2016

out of the 18 MPIP programs developed/adopted by the health plans include PCMH recognition as a qualification for receiving the incentive payments.

1. Metrics. The Agency's website contains detailed descriptions of the MPIP programs offered by the various MMA health plans, so that pediatricians and OB/GYNs can be informed about how to qualify for the incentive payments¹⁴. The health plans' respective lists of qualified providers are also posted. As the program matures, detailed reports will be generated to compare savings realized by the health plans to the incentive payments made by plans to their provider networks; to compare trends in quality indicators, such as the number of providers with PCMH recognition; and to compare performance measures and consumer satisfaction scores.

2. Health Information Technology. An important feature of the PCMH model, and a requirement for PCMH recognition, is the use of a technology network within the physician's clinic (and among clinics within a multi-clinic system). In this way, a patient's care can be tracked and coordinated, and the increased use of health information technology supports the care of each patient and helps identify and address gaps in care.

3. Prevention and Wellness--Consumer Engagement. PCMH service delivery focuses on care coordination, access to care in the most cost-effective setting, and an effective partnership between the primary care clinician, the interdisciplinary care team, and the patient and family. Patients benefit from this model of care because they have increased access to their primary care clinician and his/her interdisciplinary team; their care is tracked and coordinated; and PCMH models promote education and self-management by the patient and family. Research confirms medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.¹⁵

(4) MPIP Oversight:

The Agency's initial MPIP program was developed with extensive input from and collaboration with the MMA health plans, to ensure clarity regarding the goals of the program and to allow testing of innovative MPIP models. The Agency is monitoring several key aspects of the health plans' MPIP-related responsibilities to ensure the success of each program. Areas of focus include: 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. The Agency will continue to monitor MPIP-related feedback from the health plans and their providers, will identify best practices, and will seek opportunities to simplify and streamline the MPIP.

(5) *Adherence to the MPIP:*

The Agency may impose fines or other sanctions upon health plans that fail to initiate and operate an Agency-approved MPIP plan within two years of continuous operation by the health plan in Florida Medicaid.

¹⁴ http://ahca.myflorida.com/medicaid/statewise_mc/mma_physical_incentive.shtml

¹⁵ <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh>, December 2016

(6) Promoting Delivery Models and Best Practices:

As expected, physician awareness of and interest in achieving and maintaining PCMH recognition has increased significantly among pediatric and OB/GYN clinics in Florida, based on reports of an increased number of calls to the NCQA and other accreditation entities since implementation of the MPIP.

(C) Supporting Positive Birth Outcomes for Medicaid: MMA Design and Monitoring:

(1) Background--Florida Medicaid Program Bears Cost of the Majority of Florida Births:

The state has a primary stake in promoting positive birth outcomes. In calendar year 2015, Florida Medicaid covered the cost of 63 percent of births in the state.¹⁶ In addition, the Florida Medicaid program covered total medical costs of over \$801million for 14,837 babies who started out in Neonatal Intensive Care Units (NICU), many because they were born pre-term and/or with low birthweight. This cost reflects the fact that after discharge from the NICU, many of these premature infants continue to have significant hospital-based healthcare needs and costs during their first year of life.

In 2015, over 74,000 women whose deliveries were covered by Medicaid only attained eligibility for the program through pregnancy.¹⁷ Reproductive life planning and access to effective means of contraception prevents unplanned pregnancies and poor birth spacing, which reduces the risk of low birthweight and premature birth.

In July 2014 the Center for Medicaid and CHIP Services launched the Maternal and Infant Health Initiative to improve maternal and infant health outcomes. One of the primary goals is to increase the access and use of effective methods of contraception in order to prevent poor birth spacing and reduce unintended pregnancy, thereby reducing the risk of low-weight and/or premature birth. The Centers for Disease Control and Prevention identifies Long Acting Reversible Contraceptives (LARCs) as the most effective family planning method.

(2) MMA Health Plan Contract Requirements Supporting Positive Birth Outcomes:

(a) Healthcare Effectiveness Data and Information Set (HEDIS) Measure Reporting by Health Plans. Many factors are associated with poor birth outcomes, and the MMA contract requirements are designed to provide a broad array of prenatal and birth-related services to all pregnant enrollees to address these, including nutrition, breastfeeding, parenting, childbirth, and tobacco cessation support. In order to drive continued improvement in pregnancy outcomes and maternal and infant health, Florida Medicaid health plans are contractually required to meet standards related to national benchmarks on specific Healthcare Effectiveness Data and Information et (HEDIS) prenatal, postpartum and early childhood quality metrics.¹⁸ Health plans are subject to liquidated damages, corrective action, or sanctions for failure to meet these quality standards.

For a snapshot of overall performance for all MMA health plans for 2015, please see the table below:

¹⁶ Source: *Quarterly Statewide Medicaid Managed Care Report, Autumn 2016*. [Link](#)

¹⁷ SOBRA eligibility category covers pregnant women with incomes up to 185% of the federal poverty level.

¹⁸ Plans are required to report on three pregnancy-related HEDIS measures: Timeliness of Prenatal Care, Postpartum Care, and Frequency of Prenatal Care. Plans are also required to report on the number of Well Child Visits received within the first 15 months of life.

Prenatal and Postpartum Care, and Well-Child Visits HEDIS Measures

MMA health plans are required to report on the following four performance measures comprise the *Pregnancy-related Care* and *Keeping Kids Healthy* categories of the Medicaid Health Plan Report Card.

Performance Measure	Calendar Year 2015 Weighted Mean for FL Medicaid Plans	Comparison to CY 2014 National Mean ¹⁹ for Medicaid states reporting
Timeliness of Prenatal Care	83%	Higher
Postpartum Care	59%	Lower
Frequency of Ongoing Prenatal Care (≥ 81% of expected visits)	67%	Higher
Well-Child Visits, First 15 months (6+ visits)	58%	Lower

Additional MMA contract requirements to support positive birth outcomes include:

(b) Performance Improvement Plans (PIPs). Health plans are required to implement specific, validated²⁰ Performance Improvement Plans (PIPs) to improve their HEDIS quality metrics for prenatal, postpartum, and early childhood care. Individual health plans' progress and interim results are monitored and technical assistance is provided by Medicaid Quality PIP Teams. Please see Appendix D for interim updates of Quality PIP Team activities.

(c) Coordination with Healthy Start Coalitions at the Local Level. Another facet in the care continuum is a contractual requirement for health plans to coordinate activities on the local level with the Healthy Start Coalitions²¹ in each county. This assists in addressing the psychosocial determinants of health at the local level, and addresses the disparities in care and birth outcomes throughout this diverse state. The Healthy Start Coalitions are positioned to enhance care coordination and provide supplemental, specialized services for high-risk pregnant women with evidence-based programs delivered at the local level supported by federal and state funding sources outside of Medicaid.

¹⁹ Florida Health Finder. (2016). *Medicaid Health Plan Report Care CY 2015 Weighted means*. Retrieved from: <http://www.floridahealthfinder.gov/HealthPlans/Compare.aspx?typcd=MRC>

²⁰ Health Plans must submit their PIP plans for validation by the Agency's External Quality Review Organization prior to implementation.

²¹ See AHCA MMA Contract Attachment II, Exhibit II-A, Page 76 of 115 and AHCA Healthy Start MomCare Network Contract MED165 Attachment 1, Page 4 of 52.

(d) Healthy Behaviors Programs—Consumer Engagement. Currently, ten of 16 MMA health plans offer additional Agency-approved enrollee Healthy Behaviors Programs related to pregnancy. These Healthy Behaviors Obstetric, Prenatal or Maternal Health programs reference evidence-based practices to support the effectiveness of consumer engagement through financial rewards to motivate the enrollee to take positive action. Specific plan interventions, goals, and/or milestones must be achieved before the enrollee receives predefined incentives and/or rewards.

(e) Physician Incentive Program for OB/GYN. On October 1, 2016, Florida Medicaid initiated an MMA Health Plan Physician Incentive Payment Program that requires specific criteria that physicians must meet to qualify. The Agency model includes board-certified OB/GYNs who have met all of the predefined HEDIS measures standards, including Frequency of Ongoing Prenatal Care, Postpartum Care, and who do not exceed the overall Florida Medicaid Cesarean Section Rate.

(3) *Strategies to Assist in Reproductive Life Planning:*

According to the Guttmacher Institute, “State Facts About Unintended Pregnancy” (September 2016),²² in 2010 over half of all the pregnancies in Florida were unintended. To address this issue, Medicaid contracts require health plans provide comprehensive family planning services so that their enrollees may make informed decisions about their personal health, family size and spacing of births. The health plans are required make available and encourage all pregnant women and mothers with infants to receive specific services to support voluntary family planning, including discussion of all appropriate methods of contraception and counseling and services for family planning to all women and their partners.²³ In addition, the Healthy Start program provides specific inter-conception education and assists each woman in developing her reproductive life plan.²⁴

(4) *Continuing Health Services After Birth to Promote Birth Spacing and Early Childhood Health:*

Through the Family Planning Waiver,²⁵ Florida Medicaid provides continuing family-planning related health services for women who have lost Medicaid coverage. To further assist women in planning their family size and birth spacing, the Medicaid Family Planning waiver is designed to continue limited services, including contraception, for up to 24 months following a women’s loss of full Medicaid eligibility. Family Planning Waiver recipients are eligible for all Medicaid-covered family planning services, contraception pharmacy services, and certain antibiotics and

²² Kost K, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002*, New York: Guttmacher Institute, 2015, <https://www.guttmacher.org/report/unintended-pregnancy-rates-state-level-estimates-2010-and-trends-2002>.

²³ *State of Florida AHCA Agreement No. MED165-Agency for Health Care Administration and the Healthy Start MomCare Network, Inc., Attachment II, Exhibit II-A, Section V.(13)*. The Managed Care Plans shall establish specific programs and procedures to improve pregnancy outcomes and infant health, including, but not limited to, coordination with the Healthy Start program [F.S 409.975(4)(b); AHCA Contract, Attachment II, Exhibit II-A, Section V(14)].

²⁴ Florida Statutes mandate a contract with the Healthy Start/MomCare network to provide additional care coordination and targeted services to high-risk pregnant women. Section 383.011(1)(e), F.S. http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0300-0399/0383/0383.html

²⁵ Florida Medicaid Family Planning Waiver, October 1, 1998—December 31, 2017.

gynecological procedures. Most contraceptives available in a pharmacy and those delivered in a physician's office are covered.

(5) Stakeholder Partnerships to Support Positive Birth Outcomes in Florida:

Through outreach to other stakeholders, Florida Medicaid gained crucial knowledge and technical assistance from participation in the following partnerships:

- Participation in the privately funded LARC Technical Assistance Project which was conducted by Health Management Associates;
- Association of State and Territorial Health Officials (ASTHO) LARC Learning Community (Florida was included in Cohort 3);
- March of Dimes Prematurity Summit development of the Florida Prematurity Campaign Strategic Plan 2016-2020;
- The proven success of the South Carolina Medicaid Long Acting Reversible Contraceptive (LARC) initiative;^{26,27}
- Florida Department of Health; and
- Florida Association of Healthy Start Coalitions Healthy Start/MomCare Redesign for MMA.

In addition, systematic barrier analysis was performed at the recipient, service provider, hospital, and health plan levels to guide efforts to improve awareness of the effectiveness and access to LARCs. The Florida Medicaid program, in coordination with the Florida Department of Health has removed several operational barriers to improve access to all contraceptive methods, including:

- Development of strategies to optimize awareness and utilization of long-acting reversible contraceptives (LARCs), the most effective reversible method of contraception;
- Streamlining of reimbursement for immediate postpartum insertion of LARCs by unbundling payment from other labor and delivery services in the hospital;
- Improved, immediate access to LARCs at all County Health Department locations; and
- Improving provider awareness and addressing barriers in the outpatient clinic practice setting.

(6) Active Collaboration with the Jacksonville LARC Discussion Group and the Florida Perinatal Quality Collaborative (FPQC) to further address the barriers related to LARC access in the State of Florida:

²⁶ *The South Carolina Postpartum LARC Toolkit - Choose Well.* (2016, January). Retrieved from http://www.choosewellsc.org/SC_Postpartum_LARC_Toolkit.pdf

²⁷ By averting unintended pregnancies in the United States, cost reduction would approach \$13,000 per birth. See report, *Getting the Facts Straight*, page 35. Retrieve from: <https://thenationalcampaign.org/sites/default/files/resource-supporting-download/getting-the-facts-straight-chapter-6-savings-to-society.pdf>

The purpose of this LARC project is to expand access of LARCs for all Florida residents, including Medicaid recipients. One component of the effort to improve birth outcomes is to assist women in advance--planning to receive LARC services immediately postpartum--before leaving the hospital after giving birth. The inter-conception curriculum provided through the Healthy Start program helps educate women about their health risk factors, contraceptive options, and development of a personal reproductive life plan, and in accessing LARC postpartum, if chosen.

(7) Engagement of Medicaid Health Plans, Consumers, and Other Stakeholders:

All payers of medical costs in Florida are stakeholders in driving reduction of the prevalence of low birthweight and preterm births in the state.²⁸ Accordingly, the Florida Medicaid program is actively working to engage Medicaid health plans in addressing their respective internal barriers to LARC access; communicating the progress of the LARC Quality Initiative (QI); and by facilitating regularly scheduled steering committee calls and webinars with interested stakeholders and key partners.

Successful accomplishment of this statewide initiative will require some substantial systems changes in the hospital setting involving physicians, the pharmacy department, billing department, patient educators, and coordination to ensure that women's advance planning choices are communicated and delivered. In collaboration with a Medicaid health plan (United Healthcare) and other community stakeholders, the Jacksonville LARC group is developing a hospital-based immediate post-partum pilot initiative at University of Florida Health Jacksonville Hospital. Both the Jacksonville and the Florida Perinatal Quality Collaborative (FPQC) group efforts will contribute to the goal of eventual statewide access to LARC services for all women in the hospital postpartum setting. Please see the following graphic for an outline of the major stakeholder participants and their respective roles in these initiatives.

²⁸ According to the 2016 March of Dimes Premature Birth Report Card, Florida had a preterm birth rate of 10.0% making it the third highest ranking of the five most populous states (Texas, Illinois, Florida, Illinois, New York). [See *Premature Birth Report Cards*. (2016). March of Dimes Foundation. Retrieved from <http://www.marchofdimes.org/mission/prematurity-reportcard.aspx>.]

FLORIDA LARC PILOT INITIATIVE ORGANIZATION ROLES



(8) Consumer Engagement:

The success of these programs or efforts is contingent upon consumer engagement to promote awareness of and access to contraceptives of choice. Recipients of these services must be informed and empowered regarding contraceptive access. In addition to the education and counseling offered at prenatal visits, through the Healthy Start program, and during the inter-conception care period, direct engagement via social media platforms (websites, Facebook, Twitter, and computer applications) will provide recipients with information specific to their health factors, and how to take practical steps to access available services. Some health plans are also piloting member incentives to encourage participation in education and counseling regarding maternal and child health. Florida Medicaid contracts allow flexibility to encourage health plans to innovate, develop process improvements, and leverage system changes to drive outcomes by engaging their members. Several health plans host ongoing, in-person consumer forums around the state to solicit their members' comments and suggestions, and use this feedback to improve service toward the goal of improving health outcomes.

(D) Oral Health:

(1) History:

Tooth decay is the number one chronic disease among children²⁹ and it is a disease that is wholly preventable. Prior to the implementation of the Statewide Medicaid Managed Care program, the Agency for Health Care Administration, Division of Medicaid, provided dental services to children through prepaid dental contracts. Dental services were also provided to both children and adults through the Reform Pilot.

Now, all health plans are required to provide Medicaid covered dental services to children and adults under the Medicaid Managed Medical Assistance (MMA) program, which was implemented in 2014. It is optional for health plans to provide services to adults.

At the time of MMA implementation, the state of Florida ranked among the lowest ten percent of states' Medicaid programs in the nation for utilization rates for children's preventive dental services. Florida Medicaid has committed significant resources to increase the use of preventive dental services including new requirements for coverage and performance standards in statewide managed care contracts beginning in August of 2014.

(2) State Oral Health Action Plan:

In 2010, the Centers for Medicaid and Medicare Services (CMS) launched the Children's Oral Health Initiative. In autumn of 2014, the Agency for Health Care Administration, Division of Medicaid, was competitively selected as one of five state Medicaid agencies to participate in a dental learning collaborative. During this two-year collaborative, Florida Medicaid received technical assistance to design, develop and implement a State Oral Health Action Plan (SOHAP).

The SOHAP is a living document that identifies key drivers of change and interventions needed to meet the state oral health Medicaid goals utilizing a driver diagram and the Plan-Do-Study-Act (PDSA) cycle for rapid improvement.

Through development of the SOHAP, three interventions were implemented:

- (a) Improving Data Reporting. The CMS 416 form is used to collect basic information on each state's Medicaid and Children's Health Insurance Program (CHIP) programs to assess the effectiveness of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) efforts. The reporting period cycle for this report is the federal fiscal year.
- (b) Dental Performance Improvement Projects (PIPs) were required for each Florida Medicaid health plan.
- (c) Oral Health Consumer Engagement.

²⁹ "Children's Oral Health" Centers for Disease Control, Division of Oral Health, National Center for Chronic Disease Prevention and Health Promotion. <http://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html>, 15 Nov 2016. Web. 5 Dec 2016.

(3) Goals:

The following goals for improvement were set by the Children's Oral Health Initiative:

(a) Increase by 10 percentage points the proportion of Medicaid and CHIP children ages 1 to 20 (enrolled for at least 90 days) who receive a preventive dental service [footnote a definition of the PDENT measure/calculation] by the end of federal fiscal year 2015.

(b) The second goal was to increase by 10 percentage points the proportion of Medicaid and CHIP children ages 6 to 9 (enrolled for at least 90 days) who receive a dental sealant on a permanent molar tooth by the end of federal fiscal year 2015.

(4) Interim Results:

During FFY 2011-2012 (covering the time period of October 1, 2011 to September 30, 2012), 19% of Florida's children enrolled in Medicaid received a preventive dental service (PDENT measure). Just three years later, during FFY 2014-2015, the PDENT measure had improved to 33%. In calendar year 2010, 34% of the children visited a dentist for any service. By calendar year 2015, 47% of the children had seen a dentist. Please see the following chart for a summary of measures for all children enrolled in Florida Medicaid

Florida Medicaid Performance Measures

Performance Measure	Weighted Mean CY 2015
ADV – Total¹	47%
PDENT²	33%
TDENT³	15%
SEA⁴	13%

¹ADV-Total measures the percentage of members ages 2 to 20 who had at least one dental visit during the measurement year.

²PDENT measures the percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for EPSDT services, and who received at least one preventive dental service during the reporting period.

³TDENT measures the percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for EPSDT services, and who received at least one dental treatment service during the reporting period.

⁴SEA measures the percentage of individuals in the age categories of 6-9 and 10-14 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for EPSDT services, and who received a sealant on a permanent molar tooth during the reporting period.

No other state Medicaid program achieved this level of improvement during this time period, however there are still many children who need dental care. The goal for the next five years is to consistently attain the yearly national PDENT average. For FFY 2019-2020, this will mean that at least 44% of children will receive a preventive dental service.

(5) *Interventions:*

(a) *Improve reporting on the CMS 416 Report:* One of the first SOHAP interventions was to ensure complete and accurate Oral Health Performance Data. During 2015, staff from across Florida Medicaid performed a comprehensive review of the production of the CMS 416 report. Guided by technical support from CMS, an internal workgroup was established and the methodology for compiling the data for the CMS 416 was significantly updated, modified and improved. A single, refined query for the report production was deployed in March of 2016 to produce the 2015 CMS 416 Report. The result was a high level of confidence in the data being reported and a one percentage point increase in the preventive dental data.

(b) *Performance Improvement Project (PIP) Quarterly Check-Ins:* Federal CMS suggested enhancement to the health plans' Oral Health Performance Improvement Project (PIP). According to the Statewide Medicaid Managed Care contract, each health plan is required to complete a PIP that focuses on preventive dental care for children. CMS reviewed four of the dental PIPs to provide examples of areas that needed improvement.

CMS's suggestions and examples were utilized to develop a system for staff to analyze all of the PIPs. The findings were assessed for the key areas that needed improvement: barrier prioritization, innovative interventions, frequency of measuring, etc. We then developed the PIP check-in process to provide technical assistance to each health plan.

PIP check-in teams met with three to four health plans each at the health plan's headquarters. During the first check-ins, in March--April 2016, many common barriers, as well as various methods health plans used to prioritize those barriers were discovered, along with several common interventions, many of which seemed to be routine, administrative tasks, such as phone call reminders, member handbooks and newsletters. While health plans are required to submit PIP results annually, many of the health plans have quality teams that assess their own measures quarterly or monthly. PIP check-in teams made many recommendations, such as assessing outcomes more frequently, implementing more robust, evidence-based interventions, and utilizing resources such as the External Quality Review Organization and other state agencies. PIP check-in teams also supplied each health plan with a resource toolkit and encouraged informal dialogue between the plans and the PIP check-in teams.

The second check-ins in July--August, 2016, served as a follow up to the face-to-face meetings. PIP check-in teams evaluated the progress of the health plans. We discovered that the initial face-to-face meeting established rapport and facilitated dialogue between PIP check-in teams and health plans. Overall feedback from the health plans was positive. They indicated that they are proud to report their accomplishments and that the check-in process strengthens accountability and opens the lines of communication among quality improvement teams. When asked about the resource toolkit, the majority of health plans reported that the manual from CMS (Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans) was most helpful.

(c) *Oral Health Consumer Engagement Campaign*: The Agency's review of dental services utilization data showed that little data had been gathered first-hand from Medicaid recipients concerning their experiences and attitudes regarding use of dental services, or even their awareness of the availability of these services through their health plans.

The Agency also reviewed the Florida Institute for Health Innovation's (FIHI) consumer engagement report, which assessed barriers to care-seeking for children's oral health among low-income caregivers, including perceptions of the treatment and experiences with the dentist, feeling that the child did not yet need to see the dentist, costs,

transportation, and time, etc.³⁰ The PIP check-in intervention with health plans affirmed the FIHI findings that the most common barriers for health plans' enrollees are:

1. Lack of knowledge about Medicaid dental benefits; and
2. Lack of understanding of the importance of preventive dental care for children.

Findings from this report were also consistent with what was learned from other sources: an increase in consumer engagement, health literacy, and education is needed.

Guided by this information from recipients, and with technical support from the CMS learning collaborative staff, Medicaid Quality staff developed an additional SOHAP intervention targeted at increasing the level of engagement of families and children in accessing oral health care.

Medicaid Quality staff analyzed various approaches to overcome those barriers through engaging and educating Medicaid enrollees. Various Florida stakeholders were consulted³¹, along with other states' Medicaid staff who participated in the Children's Oral Health Initiative with CMS, in order to obtain technical assistance and learn from other states' best practices for consumer engagement. Agency staff also visited local dental providers to gain a direct perspective of daily operations and an even better understanding of barriers, and to receive constructive recommendations for improvement.

Other states' experiences influenced the following components of the Florida plan:

- Promoting awareness of the Medicaid dental benefit;
- Development of an identifiable brand for Medicaid dental benefits that is recognizable across all Medicaid health plans;
- Communicating the linkage between oral health and overall health;
- Practical information to assist consumers in finding a dentist and obtaining transportation;

³⁰ https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/clinical_quality_initiatives/docs/FIHI-2014_Consumer_Engagement_Report_Final.pdf

³¹ Florida Department of Health (to include CHD's), Florida Department of Children and Families, Florida Department of Education (to include school boards & nurses), Healthy Start, Head Start/Early Head Start Florida Institute for Health Innovation, Florida Dental Schools, Florida Dental Association, Medicaid Managed Care Plans, Healthy Kids, Oral health Florida, Florida CHAIN, Florida Alliance for Oral Health, Federal CMS, Grass Roots Partners, Special Olympics Florida, Tampa Bay Health Care Collaborative, Florida Dental Hygiene Association United Way, Early Learning Coalition

- Use of social media to communicate directly and engage with consumers; and
- Link to a consolidated source of information (consumer-friendly webpage) provided with every communication from any source.

(d) *Florida Medicaid Oral Health Consumer Engagement Plan Implementation Summary:*

From May through July 2016, the Agency developed and implemented the Oral Health Consumer Engagement plan. This began with development of the Florida Medicaid Dental Care for Your Health branding logo.



The logo reinforces the importance of oral health for overall health, and is identifiable to consumers based on its similarity to the Agency's logo. This logo is now consistently placed on all Medicaid dental webpages and print materials.

The Agency then created a Medicaid Dental webpage:

ahca.myflorida.com/MedicaidDental

The page clearly outlines what dental benefits are covered for children, the importance of preventive dental care for children, how to find a dentist, transportation resources, and the Medicaid complaint hub. All communications from AHCA or health plans about Medicaid dental benefits include this link.

In July 2016, the Agency announced these resources with a press release and launched the campaign at the Oral Health Florida conference. Staff who attended the conference promoted the campaign and developed a database of over two hundred names and contact information of those who expressed interest in helping promote awareness and use of the Medicaid dental benefit.

Staff then developed the Florida Medicaid Social Media Posting Packet, which included an official letter requesting stakeholder participation, suggested oral health messages and Medicaid dental information in the form of posts for Facebook and Twitter, graphic images of the logo, instructions for posting, and monthly tracking sheets to measure the campaign's success.

The Oral Health Consumer Engagement Plan is publicized at all internal and external meetings. The Agency continues to emphasize the importance of posting the consumer webpage link and the logo and encourages the use of the designated hashtag: #FLMedicaidDental, which will enable tracking of the messages as they spread on social media. In addition to monitoring the hashtag, monthly tracking sheets will be completed by stakeholders, and the number of unique "hits" to the consumer webpage can also be tracked.

(e) Ongoing Activities and Status:

1. Streamlined CMS-416 Query: A multidisciplinary team ensures that the query for the CMS 416 report is kept up to date with all new procedure codes and CMS reporting instructions.

2. PIP Check-in Teams: PIP check-in teams continue to meet with health plans on a quarterly basis for structured, focused reviews of their performance improvement efforts. The next quarterly PIP check-ins will focus on improving prenatal care and promoting well-child visits within the first fifteen months of life.

3. Oral Health Consumer Engagement:

a. The initial campaign will last six months, after which the data and feedback will be assessed and the campaign will be tweaked or redesigned if necessary. The next phase will include messaging in Spanish and Creole. Assessment will be made to measure any increase in utilization of services; awareness of Medicaid dental benefits; knowledge of the importance of preventive dental health; and knowledge of how to access services.

b. Additional materials are being created for distribution to all Medicaid field offices, as well as to ACCESS centers (the physical locations throughout the state where recipients go to sign up for social service benefits).

Resources:

Recommendations from CMS on Dental PIP's:



Analysis of 4 PIPs
(003).docx



A Few Thoughts
from CMS on PIP Int

PIP check-in process:



FORM_PIPCheckIns
_020416 (002).docx



PIP Check In
Training Slides.pptx



Check Lists.docx



Check-in Intro.docx

PIP Resource Toolkit:



Medicaid Health
Resource Kit (Dental)

Consumer Engagement Plan:



Oral Health
Consumer Engagem



10974 - Oral Health
Bookmark - 07-08-20



Florida Medicaid
Oral Health Social M

Social Media Measurement:



FacebookTracking.
docx



TwitterTracking.doc
x



Social Media.pdf

APPENDIX 1 Managed Care Contract Provisions

A. External Quality Review Requirements

As noted in the Introduction, the state’s MCO and PIHP contracts require the entities to be subject to annual, external independent review of the quality outcomes, timeliness of, and access to, the services covered in accordance with 42 CFR 438.204.

Each year, 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 which incorporate this requirement can be found by contract in Table 1.

<i>Table 1 External Quality Review 42 CFR 438 Subpart E</i>	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, A.1.b.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, A.1.b.

B. The Level of Contract Compliance of MCO(s)/PIHP(s)

MCO/PIHP Requirements

1. Availability of Services

The state’s MCO and PIHP 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, in regard to managed care. MCO and PIHP access to care contract requirements are summarized in this section. The table following each standard

provides the location where this requirement can be found in each of the state's MCO and PIHP contracts.

(a) Maintains and Monitors a Network of Appropriate Providers

The state's MCO and PIHP contracts require each entity to establish and maintain a network of appropriate providers that is 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. Each entity's network of appropriate providers must be supported by written agreements.

The state requires the MCOs and PIHPs 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 PIHPs 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 Coverage and Limitations 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 PIHPs to make emergency medical care available on a 24 hours a day, seven days a week basis. 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 which incorporates the state’s MCO and PIHP delivery network requirements can be found by contract in Table 2.

<i>Table 2</i> <i>Delivery Network Requirements</i> 42 CFR 438.206(b)(1)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, A.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, A.

(b) Provides female enrollees with direct access to a women’s health specialist.

The state requires MCOs and PIHPs 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 which incorporates this requirement can be found by contract in Table 3.

<i>Table 3</i> <i>Direct Access to Women's Health Specialist</i> 42 CFR 438.206(b)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section VI, A.4.a.(2)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section VI, A.4.a.(2)

(c) Second Opinion from a Qualified Health Care Professional.

The state requires each MCO and PIHP 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 which incorporates this requirement can be found by contract in Table 4.

<i>Table 4</i> <i>Second Opinion Requirement</i> 42 CFR 438.206(b)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section IV, A.7. b.(8)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section IV, A.7. b.(8)

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

The state requires MCOs or PIHPs 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 PIHP is unable to provide them in compliance with 42 CFR 438.206(b)(4).

The reference to the contract provision which incorporates this requirement can be found by contract in Table 5.

<i>Table 5</i> <i>Outside the Network</i> 42 CFR 438.206(b)(4)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Care Program	Attachment II, Exhibit A, Section V, A.1.a.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section V, A.1.a.

(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 which incorporates this requirement can be found by contract in Table 6.

<i>Table 6</i> <i>Coordination with Outside the Network Providers</i> 42 CFR 438.206(b)(5)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section V, A.10-.h.-i p. 24- 25 and A.11.m.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section V, A.10-.h.-i p. 24- 25 and A.11.m.

(f) Demonstration of Providers' Credentialing.

The state requires the MCOs and PIHPs 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 s. 409.967(2)(e)3., 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 the managed care plan is accredited by a nationally recognized body. 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 PIHPs' written policies and procedures for credentialing of providers to ensure compliance with all applicable federal and state regulations.

The reference to the contract provision which incorporates this requirement can be found by contract in Table 7.

<i>Table 7</i> <i>Provider Credentialing</i> 42 CFR 438.206(b)(6)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, C.2.a. (4)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, C.2.a. (4)

(g) Timely Access to Care.

The state requires the MCOs and PIHPs 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 PIHP, 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 PIHPs 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 which incorporate these requirements can be found by contract in Table 8.

<i>Table 8</i> <i>Timely Access to Care</i> 42 CFR 438.206(c)(1)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, , C.6.c.(6) and A.4
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, , C.6.c.(6) and A.4

(h) Cultural Considerations.

The state requires the MCOs and PIHPs 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. The plans are required to 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 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, among others:

- 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; and
- 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.

The reference to the contract provision which incorporates this requirement can be found by contract in Table 9.

<i>Table 9</i> <i>Cultural Considerations</i> 42 CFR 438.206(c)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section IV, B.4.a.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section IV, B.4.a.

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 PIHPs are required to submit documentation that demonstrates the plan: (1) offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of enrollees for the service area; and (2) maintains a network of appropriate providers that is 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 that is 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 which incorporates this requirement can be found by contract in Table 10.

<i>Table 10</i> <i>Documentation of Adequate Capacity & Services</i> 42 CFR 438.207(b)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, A.1.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, A.1.

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

The state requires the MCOs and PIHPs 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.

If a plan intends to terminate services, at least sixty (60) days before the termination effective date, the plan must provide written notification to all enrollees of 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 which incorporates this requirement can be found by contract in Table 11.

<i>Table 11</i> <i>Sufficient Network of Providers</i> 42 CFR 438.207(c)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, A.2.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, A.2.

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 PIHPs 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 PIHPs are required to offer each enrollee a choice of primary care physicians. After making a choice, each member shall have a single 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 which incorporates this requirement can be found by contract in Table 12.

<i>Table 12</i> <i>On-going Source of Primary Care</i> 42 CFR 438.208(b)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b

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

Pursuant to 42 CFR 428.208(b), the state requires the MCOs and PIHPs 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 which incorporates this requirement can be found by contract in Table 13.

<i>Table 13</i> <i>Coordination of Services</i> 42 CFR 438.208(b)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section V. E.2.b
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section V. E.2.b

(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 PIHPs 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 which incorporates this requirement can be found by contract in Table 14.

<i>Table 14</i> <i>Duplicative Services for Individuals with Special Health Care Needs</i> 42 CFR 438.208(b)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section V. D.3.a.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section V. D.3.a.

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

Pursuant to 42 CFR 428.208(b), 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. Pursuant to 42 CFR 438.224 and consistent with 42 CFR 431 subpart F, 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 references to the contract provisions which incorporate these requirements can be found by contract in Table 15.

<i>Table 15</i> <i>Privacy Protection</i> 42 CFR 438.224 and 42 CFR 431 subpart F	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section V, E.2.a.(7) and Section I, A
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section V, E.2.a.(7) and Section I, A

(e) Additional Services for Persons with Special Health Care Needs, including: (i) Identification; (ii) Assessment; (iii) Treatment Plans, and (iv) Direct Access to Specialists.

The state requires the MCOs and PIHPs 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 plan's treatment plan for an enrollee determined to need a course of treatment or regular care monitoring must be developed by the enrollee's primary 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)) to need a course of treatment or regular care monitoring, each plan must 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 reference to the contract provision which incorporates this requirement can be found by contract in Table 16.

The reference to the contract provision which incorporates this requirement can be found by contract in Table 16.

<i>Table 16</i> <i>Additional Services for Individuals with Special Health Care Needs</i> 42 CFR 438.208(c)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b; Exhibit A, Section V, E.2.b and E.4.c.(8)(11)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b; Exhibit A, Section V, E.2.b and E.4.c.(8)(11)

4. Coverage and authorization of services

(a) The Amount, Duration and Scope of Each Service that Florida MCOs and PIHPs are Required to Offer.

The state requires the MCOs and PIHPs 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 PIHPs 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 handbooks 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 handbooks. 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, Quality and Benefit Enhancements or Quality Enhancements. These services must be specifically 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. The state may restrict the plan's enrollment activities if acceptable quality improvement and performance indicators based on HEDIS and other outcome measures to be determined by the state are not met. Such restrictions may include the termination of mandatory assignments.

Plan members who require services available through Medicaid but not covered by the plan's contract may receive these services through the existing Medicaid fee-for-service reimbursement system. The MCOs and PIHPs 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 PIHPs 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 which incorporates these requirements can be found by contract in Table 17.

<i>Table 17</i> <i>Coverage of Services</i> 42 CFR 438.210(a)(1)(2)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section II, D. 12 and 18; Section V, A.1, a-d
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section II, D. 12 and 18; Section V, A.1, a-d

(b) What Constitutes “Medically Necessary Services” in Florida MCOs and PIHPs?

The state requires that the MCO and PIHP 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 59G-1.010(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 which incorporate this requirement can be found by contract in Table 18.

<i>Table 18</i> <i>Medically Necessary Services</i> 42 CFR 438.210(a)(4)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section I and Section II, D.13
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section I and Section II, D.13

(c) Florida MCO and PIHP Written Policies and Procedures for Authorization of Services.

The state requires the MCOs and PIHPs 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 PIHPs 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, 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, 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 non-contracting 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, among others:

- 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 PIHPs 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, which may be requested by a provider or the enrollee, after the issuance of a denial.
 5. 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).

- 6. 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 which incorporate the prior authorization requirements can be found by contract in Table 19.

<i>Table 19</i> <i>Service Authorization Policies & Procedures.</i> 42 CFR 438.210(b)(d)(1)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section II, D.20; Section IV, A.7.b.(8); Section VII, G.2.e-h
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section II, D.20; Section IV, A.7.b.(8); Section VII, G.2.e-h

(d) Requirement that Decisions to Deny Services are Made by an Appropriate Health Care Professional.

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 which incorporates this requirement can be found by contract in Table 20.

<i>Table 20</i> <i>Appropriate Health Care Professional / Denial of Services</i> 42 CFR 438.210(b)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, G.4.a
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, G.4.a

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. This includes individuals with intellectual disabilities or related conditions; individuals with serious chronic illnesses, such as human immunodeficiency virus (HIV), schizophrenia or degenerative neurological disorders; individuals with disabilities resulting from many years of chronic illness such as arthritis, emphysema or diabetes; children/adolescents and adults with 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 PIHPs 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 PIHPs to assess new enrollees using a health risk assessment tool to identify persons with special health care needs. The MCO and PIHP 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 PIHPs 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 impact 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 which incorporates this requirement can be found by contract in Table 21.

<i>Table 21</i> <i>Identification of Persons with Special Health Care Needs</i> 42 CFR 438.208(c)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b; Section II, D.18; Exhibit A, Section V, E.4.c
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b; Section II, D.18 Exhibit A, Section V, E.4.c

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

The state requires the MCOs and PIHPs 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 which incorporates this requirement can be found by contract in Table 22.

<i>Table 22</i> <i>Treatment Plan Standard</i> 42 CFR 438.208(c)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section V, E.4.c.(8)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Exhibit A, Section V, E.4.c.(8)

D. Standards for Structure and Operations and Contract Provisions

1. Provider Selection

The state requires the MCOs and PIHPs 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 PIHPs 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 which incorporate this requirement can be found by contract in Table 23.

<i>Table 23</i> <i>Provider Selection and Retention, Credentialing and Recredentialing, Nondiscrimination, and Excluded Providers</i> 42 CFR 438.12(a)(2), 42 CFR 438.214(a)-(d), 42 CFR 438.206(b)(6)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, C.2., C.5., C.2.a., C.2.a.(4), C.5.b.; Section VIII, F.4.d.(12-13)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, C.2., C.5., C.2.a., C.2.a.(4), C.5.b.; Section VIII, F.4.d.(12-13)

2. Enrollee Information

The state requires the MCOs and PIHPs 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 shall 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/InspectorGeneral/fraud_complaintform.aspx;

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 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 about the Beneficiary Assistance Program (BAP) process, including an explanation that a review by the BAP must be requested within one (1) year after the date of the occurrence that initiated the appeal, how to initiate a review by the BAP and the BAP address and telephone number:

Agency for Health Care Administration
Beneficiary Assistance Program
Building 3, MS #26
2727 Mahan Drive, Tallahassee, FL 32308
(850) 412-4502
(888) 419-3456 (toll-free)

- 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 non-compliance 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 which incorporate this requirement can be found by contract in Table 24.

<i>Table 24</i> <i>Enrollee Information</i> Section 1932(b)(3), of Social Security Act and 42 CFR 438.10(f)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section III, B.1.f., C.1.b., B.1.d; Section IV, B.1.c., , A.7.a.b.1-25., A.10.a.(2).; Section V, C.2.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section III, B.1.f., C.1.b., B.1.d; Section IV, B.1.c., , A.7.a.b.1-25., A.10.a.(2).; Section V, C.2.

3. Confidentiality

During the initial MCO and PIHP 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 which incorporates this requirement can be found by contract in Table 25.

<i>Table 25</i> <i>Confidentiality</i> 45 CFR parts 160 and 164, 42 CFR 438.224	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section V, E.2.a.(7)
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section V, E.2.a.(7)

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

- a. If the plan's contract is renewed, the enrollment status of all enrollees shall continue uninterrupted.
- b. 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 shall 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 PIHP 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 shall 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 PIHPs 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 PIHP 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 PIHPs 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. The plan may leave state community outreach materials at health fairs/public events at which the plan participates.
- c. 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 choice counselor/enrollment broker. State approval of the script used by the plan's member services section must be obtained before usage.

The reference to the contract provisions which incorporate these requirements can be found by contract in Table 26.

<i>Table 26</i> <i>Enrollment & Disenrollment</i> 42 CFR 438.56, 438.6, 42 CFR 438.10, 42 CFR 422.208, 42 CFR 422.210, 42 CFR 431.230, 42 CFR 438.400 through 42 CFR 438.424	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section III, B.1.f., C.1.b., B.1.d.; Section IV, B.1.c., , A.7.a., A.7.b.2, 3, 14-15, 7-8, 9, 6-10, A.7.b., A.2.a. and C.1.4.e(2)., A.1., A.7b.(14-16), A.7.b(21).b., A.7.b(22).
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section III, B.1.f., C.1.b., B.1.d.; Section IV, B.1.c., , A.7.a., A.7.b.2, 3, 14-15, 7-8, 9, 6-10, A.7.b., A.2.a. and C.1.4.e(2)., A.1., A.7b.(14-16), A.7.b(21).b., A.7.b(22).

1. Grievance System

The state requires the MCOs and PIHPs 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 PIHPs' grievance systems to include an 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 PIHPs' 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 DCF address for pursuing a fair hearing, which is:

Office of Appeal Hearings

1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700
Phone: (850) 488-1429
Fax: (850) 487-0662
Email: Appeal_Hearings@dcf.state.fl.us

- 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 PIHP 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 PIHP 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 PIHPs 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 may 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.

- c. Submission to the Beneficiary Assistance Program (BAP) for FFS PSN or the Statewide Subscriber Program (SAP) for prepaid health plans. After the BAP program sunsets in October 2014, submission will be to the Subscriber Assistance Program (SAP).
 - 1) The original grievance must be filed with the plan in writing.
 - 2) The submission of the grievance to the BAP/SAP must be done within one year of the date of the occurrence which initiated the grievance.
 - 3) The grievance may be filed if it concerns:
 - a) The quality of health care services; or
 - b) Matters pertaining to the contractual relationship between an enrollee and the plan.

The state requires the MCOs and PIHPs 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 must 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;
 - b) 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;
 - c) A Medicaid fair hearing decision adverse to the enrollee is made; or
 - d) 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;
 - b) Information about how to request a Medicaid fair hearing, including the Florida Department of Children and Families address for pursuing a Medicaid fair hearing, which is:

Office of Appeal Hearings
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700
Phone: (850) 488-1429
Fax: (850) 487-0662

Email: Appeal_Hearings@dcf.state.fl.us
 - c) Notice of the right to continue to receive benefits pending a Medicaid fair hearing;
 - d) Information about how to request the continuation of benefits; and
 - e) 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 Florida Department of Children and Families address for pursuing a fair hearing, which is:

Office of Appeal Hearings
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700
Phone: (850) 488-1429
Fax: (850) 487-0662

Email: Appeal_Hearings@dcf.state.fl.us

- 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.
- b. Submission to the BAP for FFS PSN and the SAP for Prepaid Health Plans.
- 1) The submission of the appeal to the BAP or the SAP must be done within one year of the date of the occurrence that initiated the appeal.
 - 2) An enrollee may submit an appeal to the BAP or SAP if it concerns:
 - a) The availability of health care services or the coverage of benefits, or an adverse determination about benefits made pursuant to UM; or
 - b) Claims payment, handling, or reimbursement for benefits.
 - 3) If the enrollee has taken the appeal to a Medicaid fair hearing, the enrollee cannot submit the appeal to the BAP or SAP.

7. Medicaid Fair Hearing System

a. Request for a 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 Florida Department of Children and Families at:

Office of Appeal Hearings
1317 Winewood Boulevard, Building 5, Room 255
Tallahassee, Florida 32399-0700
Phone: (850) 488-1429
Fax: (850) 487-0662
Email: Appeal_Hearings@dcf.state.fl.us

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 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 which incorporate the grievance system requirements can be found by contract in Table 27.

<i>Table 27</i> <i>Grievance System</i> 42 CFR 431.200 and 438, Subpart F	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section I, A; Section IV, C; Section VII, G.6.a.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section I, A; Section VII, G.6.a.

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(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4, 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 PIHP contracting process, the state ensures the plans' subcontractual relationships and delegations comply with 42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4. 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(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4.

The references to the contract provision which incorporates this requirement can be found by contract in Table 28.

<i>Table 28</i>	
<i>Subcontracted Relationships & Delegation</i>	
42 CFR 438.6(l), 42 CFR 438.230(a), 42 CFR 438.230(b)(1),(2),(3), SMM 2087.4	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VIII, B.1-3.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VIII, B.1-3.

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. The references to the contract provision which incorporates the grievance requirements can be found by contract in Table 27.

Other components of the MCO and PIHP contracts that are reviewed by the state during the on-site 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

F. Standards for Quality Measurement and Improvement and Contract Provisions

1. Practice Guidelines

Pursuant to 42 CFR 438.236(b), the state requires the MCOs and PIHPs 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 PIHPs 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 which incorporates the practice guidelines requirements can be found by contract in Table 29.

<i>Table 29</i> <i>Practice Guidelines</i> 42 CFR 438.236(b)(c)(d)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, G.3.a.b.c.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, G.3.a.b.c.

2. Quality Assessment & Performance Improvement Program

The state requires the MCOs and PIHPs 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 which incorporates this requirement can be found by contract in Table 30.

Table 30 Quality Assessment & Performance Program 42 CFR 438.240(a)(1)(a)(2)(b)(3)(4)	
Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VII, A.1.a.; Section VI, B.2.d.
Prepaid Inpatient Health Plans	
Long-term Care Program	Attachment II, Section VII, A.1.a.; Section VI, B.2.d.

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 PIHPs' 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 438.240, 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 recertification, recontracting, 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 which incorporates this requirement can be found by contract in Table 31.

<i>Table 31</i> <i>Performance Improvement Projects</i> 42 CFR 438.240(b)(1)(b)(2)(c)(d)(1)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, A.1.b and d; A.6.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, A.1.b and d; A.6.

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 PIHP 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

1. Availability of Critical Systems Functions.

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.

6. Exceptions to System Availability Requirement.

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.

7. Corrective Action Plan.

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.

4. Changes to Manuals.

- 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 (HEIC) 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 PIHP 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

2. Methods for Data Exchange.

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 which incorporates these requirements can be found by contract in Table 32.

Table 32 Health Information Systems 42 CFR 438.242(a)(b)(1)(2)(3)	
Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, .; Section II, D.22.; Section VIII, C.3.a-h, C.4.a-h., C.5.a-d., C.6.a-e., C.7., C.9.a and b., C.11.b and c.
Prepaid Inpatient Health Plans	
Long-term Care Program	Attachment II, .; Section II, D.22.; Section VIII, C.3.a-h, C.4.a-h., C.5.a-d., C.6.a-e., C.7., C.9.a and b., C.11.b and c.

Table 33 provides a summary list of the reports required by the state for contracts operated under the 1115 Demonstration Waiver as of October 1, 2014. The SMMC Report Guide containing detailed instructions for these reports can be accessed at:

http://ahca.myflorida.com/Medicaid/statewide_mc/report_guide.shtml

Table 33 Medicaid Managed Care Required Reports		
Contract Section	Report Name	Frequency
Section IX and XIV	Achieved Savings Rebate Financial Reports	Annually Quarterly
Section XII and XIV	Administrative Subcontractors and Affiliates Report	Quarterly, within fifteen (15) calendar days after the end of the reporting quarter.
Section VIII and XIV	Annual Fraud and Abuse Activity Report	Annually, by September 1 st .

Table 33
Medicaid Managed Care Required Reports

Contract Section	Report Name	Frequency
Section X and XIV	Audited Annual and Unaudited Quarterly Financial Reports	Audited - Annually , on or before April 1 following the end of each reporting calendar year; Unaudited - Quarterly , within 45 calendar days after the end of each reporting quarter.
Section VII and XIV	Code 15 Report	Variable , within fifteen (15) calendar days after the Managed Care Plan received information about the incident.
Exhibit II-A, Section V and XIV	CHCUP (CMS-416) & FL 80% Screening	Unaudited - Annually , on or before January 15 following the end of the reporting federal fiscal year (October 1 through September 30); Audited - Annually , on or before October 1 following the end of the reporting federal fiscal year (October 1 through September 30).
Section VII and XIV	Critical Incident Report	Variable , immediately upon occurrence and no later than twenty-four (24) hours after detection of notification.
Exhibit II-A, Section V and XIV	Hernandez Settlement Ombudsman Log	Quarterly , fifteen (15) calendar days after the end of the reporting quarter.
Exhibit II-A, Section V and XIV	Hernandez Settlement Agreement Survey	Annually , on or before August 1 of each year.
Section VII and XIV	Critical Incident Summary Report	Monthly , by the fifteenth (15 th) calendar day of the month following the reporting month and rolled up for quarter and year.
Section IV and XIV	Enrollee Complaints, Grievances, and Appeals Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.
Section IV. D.5.h. and XIV	Enrollee Help Line Statistics Report	Monthly

Table 33
Medicaid Managed Care Required Reports

Contract Section	Report Name	Frequency
Section IV. D.5.g. and XIV	Marketing Agent Termination Report	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.
Section IV. B.5.a. and XIV	Market/Educational Events Report	Monthly , no later than the twentieth (20 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.
Section VII; Exhibit II-B, Section V and VII; Exhibit II-A, Section V	Performance Measures Report – LTC and MMA	Annually , by July 1, for the prior calendar year.
Section VI and XIV	Provider Complaint Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.
Section VI and XIV	Provider Network File	Weekly , on Thursday by 5:00 p.m. EST.
Section VI and XIV	Provider Termination and New Provider Notification Report	Weekly , on Wednesday by 5:00 p.m. EST.
Section VIII and XIV	Quarterly Fraud & Abuse Activity Report	Quarterly , within fifteen (15) calendar days after the end of the quarter being reported.
Section VIII and XIV	Suspected/Confirmed Fraud and Abuse Reporting	Variable , within fifteen (15) calendar days of detection.
Exhibit II-B, Section V and XIV	Case Management File Audit Report	Quarterly , within 30 calendar days after the end of the reporting quarter.

Table 33
Medicaid Managed Care Required Reports

Contract Section	Report Name	Frequency
Exhibit II-B, Section V and XIV	Case Management Monitoring and Evaluation Report	Quarterly , within 30 calendar days after the end of the quarter; Annual roll-up , within 30 calendar days after the end of the fourth (4 th) calendar quarter.
Exhibit II-B, Section V and XIV	Case Manager Caseload Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.
Exhibit II-B, Section V and XIV	Denial, Reduction, Suspension or Termination of Services Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.
Exhibit II-B, Section V and XIV	Enrollee Roster and Facility Residence Report	Monthly , within fifteen (15) calendar days after the beginning of the reporting month.
Section VIII and XIV	Claims Aging Report & Supplemental Filing Report	Quarterly , within forty-five (45) calendar days after the end of the reporting quarter; Capitated Managed Care Plans , optional Supplemental Filing Report is due within one hundred-five (105) calendar days after the end of each reporting quarter.
Exhibit II-B, Section V and XIV	Missed Services Report	Monthly , within thirty (30) calendar days after the end of the reporting month.
Section X and XIV	Audited Annual and Unaudited Quarterly Financial Reports	Audited – Annually, Unaudited – Quarterly,
Exhibit II-B, Section V and XIV	Participant Direction Option (PDO) Roster Report	Monthly , within fifteen (15) calendar days after the end of the reporting month.

Table 33
Medicaid Managed Care Required Reports

Contract Section	Report Name	Frequency
Exhibit II-B, Section V and XIV	Patient Responsibility Report	Annually , by October 1, for the prior Contract year.
Exhibit II-A, Section VI and XIV	Additional Network Adequacy Standards Report	Monthly
Exhibit II-A, Section V and XIV	ACA PCP Payment Increase Report	Quarterly , by the last day of the month after the end of the reporting quarter.
Exhibit II-A, Section V and XIV	Customized Benefit Notification Report	Monthly
Exhibit II-A, Section VI and XIV	Electronic Health Records Standards Report	Quarterly
Exhibit II-A, Section V and XIV	ER Visits for Enrollees without PCP Appointment Report	Monthly
Exhibit II-A, Section V and XIV	Healthy Behaviors Report	Quarterly
Exhibit II-A, Section V and XIV	Patient Centered Medical Home (PCMH) Providers Report	Quarterly
Exhibit II-A, Section V and XIV	PCP Appointment Report	Annually
Exhibit II-A, Section VI and XIV	Timely Access/PCP Wait Times Report	Annually , on or before February 1, following the reported calendar year.

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 which incorporates this requirement can be found by contract in Table 34.

<i>Table 34</i> <i>Assessment of the Quality & Appropriateness of Care and Services</i> 42 CFR 438.208(c)(2)(3)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b., E.4.c.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b., E.4.c.

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 can be found by contract in Table 35.

<i>Table 35</i> <i>Identification and Assessment of Individuals with Special Health Care Needs</i> 42 CFR 438.208(c)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b.
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b.

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 PIHPs, 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 PIHPs, 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/PIHP 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 PIHPs 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 PIHPs through desk reviews.

The references to the contract provision which incorporates these requirements can be found by contract in Table 36.

<i>Table 36</i> <i>Monitoring and Evaluation</i> 42 CFR 438.240(d)(2)	
Plan Type	Contract Provision
<i>Managed Care Organizations</i>	
Managed Medical Assistance Program	Attachment II, Section VII, A.5.d.4.(b).
<i>Prepaid Inpatient Health Plans</i>	
Long-term Care Program	Attachment II, Section VII, A.5.d.4.(b).

Intermediate Sanctions

The MCO and PIHP 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 PIHP:

- 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—
 - (1) 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
 - (2) There is substantial risk to enrollees' health; or
 - (3) 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.

- (b) 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.
- (c) The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.
- (d) The state may not terminate temporary management until it determines that the plan can ensure that the sanctioned behavior will not recur.
- 3. Granting enrollees the right to terminate enrollment without cause and notifying affected enrollees of their right to disenroll.
- 4. Suspension or limitation of all new enrollment, including default enrollment, after the effective date of the sanction.
- 5. 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.
- 6. 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.

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 which incorporates this requirement can be found by contract in Table 37.

Table 37 MCO Intermediate Sanctions 42 CFR 438 Subpart I	
Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section XI, A.-D., A.2.; Section XIII, B.; Section III, C.3.b.(9).
Prepaid Inpatient Health Plans	
Long-term Care Program	Attachment II, Section XI, A.-D., A.2.; Section XIII, B.; Section III, C.3.b.(9).

Appendix 2

Measuring Plans' Performance

I. Statewide Medicaid Managed Care (SMMC)

A. Required Performance Measures

Table 1 provides the list of performance measures that all SMMC plans were required to report to the Agency on July 1, 2016, for calendar year 2015.

Table 1	
Required SMMC Performance Measures for Calendar Year 2015	
1	Call Answer Timeliness (CAT)

Table 2 lists the statewide weighted means for the HEDIS[®] measure that was submitted by all SMMC plans for calendar year 2015 compared to its national Medicaid mean.

Table 2		
Calendar Year 2015		
SMMC HEDIS Performance Measure Results		
Measure	CY 2015 Weighted Mean	CY 2015 Comparison to National Medicaid Mean
Call Answer Timeliness	84%	Higher

1. Performance Measure Sanctions

One (1) HEDIS measure will be compared to the National Committee for Quality Assurance (NCQA) HEDIS National Means and Percentiles. The Call Answer Timeliness HEDIS measure has a threshold rate (percentage) that may trigger a sanction, as indicated in Table 3 below.

Table 3	
Core Contract Performance Measure Sanctions – Effective 8/01/2014 – 8/31/2019	
HEDIS Measures	Rate and applicable sanction
Call Answer Timeliness	Rate < 25 th percentile - immediate monetary sanction and PMAP may be imposed Rate < 50 th percentile - PMAP may be required

2. Performance Measure Liquidated Damages

The SMMC performance measure liquidated damages amount for the Call Answer Timeliness HEDIS measure is outlined in Table 4 below.

Table 4	
SMMC Performance Measure Liquidated Damages Amount	
Failure to have a rate at or above the 50 th percentile for the Call Answer Timeliness measures as described in the Contract.	\$100 per each case in the denominator not present in the numerator for the measure up to the 50 th percentile rate.

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 via 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. It 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.

Health plans can also choose 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 two 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). Five HEDIS measures, four of which are in the Core Sets, have been adopted by the Agency (Adherence to Antipsychotic Medications for Individuals with Schizophrenia, Annual Monitoring for Patients on Persistent Medications, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Metabolic Monitoring for Children and Adolescents on Antipsychotics, and Use of Multiple Concurrent Antipsychotics in Children and Adolescents). All of the Child Health Check-Up Report (CMS-416), Child Core Set, and Adult Core Set measures listed in Table 5 have been added to the list of required MMA plan performance measures within the last two years.

Table 5 provides the list of performance measures that the MMA health plans were required to report to the Agency on July 1, 2016, for calendar year 2015.

HEDIS		Children's and/or Adult Core Set Measure
1	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	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 Dental Visit (ADV)	No
6	Annual Monitoring for Patients on Persistent Medications (MPM)	Yes
7	Antidepressant Medication Management (AMM)	Yes
8	Adult BMI Assessment (ABA)	Yes
9	Breast Cancer Screening (BCS)	Yes
10	Cervical Cancer Screening (CCS)	Yes
11	Childhood Immunization Status (CIS) – Combo 2 and 3	Yes
12	Children and Adolescents' Access to Primary Care Practitioners (CAP)	Yes
13	Chlamydia Screening in Women (CHL)	Yes

14	<p>Comprehensive Diabetes Care (CDC)</p> <ul style="list-style-type: none"> • Hemoglobin A1c (HbA1c) testing • HbA1c poor control • HbA1c good control (<8%) • Eye exam (retinal) performed • Medical attention for nephropathy 	Yes
15	Controlling High Blood Pressure (CBP)	Yes
16	Follow-up Care for Children Prescribed ADHD Medication (ADD)	Yes
17	Frequency of Ongoing Prenatal Care (FPC)	Yes
18	Immunizations for Adolescents (IMA)	Yes
19	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Yes
20	Lead Screening in Children (LSC)	
21	Medication Management for People with Asthma (MMA)	Yes
22	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	
23	Prenatal and Postpartum Care (PPC)	Yes
24	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	Yes
25	Well-Child Visits in the First 15 Months of Life (W15)	Yes
26	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Yes
Agency-Defined Performance Measures		
27	Follow-Up after Hospitalization for Mental Illness (FHM)	Yes
28	Highly Active Anti-Retroviral Treatment (HAART)	No
29	HIV-Related Medical Visits (HIVV)	No
30	Mental Health Readmission Rate (RER)	No
31	Transportation Timeliness (TRT)	No
32	Transportation Availability (TRA)	No
Child Health Check-Up Report (CMS-416)		
33	Dental Treatment Services (TDENT)	No
34	Sealants (SEA)	No

Child Core Set		
35	Preventive Dental Services (PDENT)	Yes
36	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL)	Yes
37	HPV Vaccine for Female Adolescents (HPV)	Yes
38	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC)	Yes
Adult Core Set		
39	Antenatal Steroids (ANT)	Yes
40	Plan All-Cause Readmissions (PCR)	Yes
41	HIV Viral Load Suppression (VLS)	Yes
42	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	Yes

*AMB is a utilization measure and has not been compared against a national benchmark.

Table 6 lists the statewide weighted means for HEDIS measures that were submitted for calendar year 2015 compared to their respective national Medicaid means. NCQA calculates national means and percentiles each year for HEDIS measures based on submissions of HEDIS performance measure results from Medicaid plans across the country. Each year, Florida Medicaid plans are compared to the national means and percentiles for all Medicaid plans.

Table 6 Calendar Year 2015 MMA HEDIS Performance Measure Results		
Measure	CY 2015 Weighted Mean	CY 2015 Comparison to National Medicaid Mean
Adherence to Antipsychotic Medications for Individuals with Schizophrenia - (SAA)	59%	Lower
Adolescent Well-Care Visits	53%	Higher
Adults' Access to Preventive Care - 20-44 Years	69%	Lower
Adults' Access to Preventive Care - 45-64 Years	85%	Lower
Adults' Access to Preventive Care - 65+ Years	77%	Lower
Adults' Access to Preventive Care - total	75%	Lower

Adult BMI Assessment	86%	Higher
Annual Dental Visit - total	47%	Lower
Annual Monitoring for Patients on Persistent Medications - ACEs/ARBs	91%	Higher
Annual Monitoring for Patients on Persistent Medications - Digoxin	55%	Higher
Annual Monitoring for Patients on Persistent Medications - Diuretics	91%	Higher
Annual Monitoring for Patients on Persistent Medications - total	91%	Higher
Antidepressant Medication Management - Acute	52%	At the mean
Antidepressant Medication Management - Continuation	37%	At the mean
Breast Cancer Screening	61%	Higher
Call Answer Timeliness	84%	Higher
Cervical Cancer Screening	51%	Lower
Childhood Immunization Status - Combo 2	77%	Higher
Childhood Immunization Status - Combo 3	72%	Higher
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-24 months	95%	At the mean
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 25 months-6 years	89%	Higher
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 7-11 years	89%	Lower
Children & Adolescents' Access to Primary Care Practitioners (PCPs) - 12-19 years	86%	Lower
Chlamydia Screening - 16-20 years	59%	Higher
Chlamydia Screening - 21-24 years	69%	Higher
Chlamydia Screening - total	62%	Higher
Comprehensive Diabetes Care - HbA1c Testing	81%	Lower
Comprehensive Diabetes Care - HbA1c Poor Control (INVERSE)*	48%	Higher (Worse)
Comprehensive Diabetes Care- HbA1c Good Control (<8%)	43%	Lower

Comprehensive Diabetes Care - Eye Exam	51%	Lower
Comprehensive Diabetes Care - Nephropathy	92%	Higher
Controlling Blood Pressure	50%	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - 13-17 years of age	10%	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - 18+ years of age	5%	Lower
Engagement of Alcohol and Other Drug Dependence Treatment - total	6%	Lower
Follow-up after Hospitalization for Mental Illness - 7 day	36%	Lower
Follow-up after Hospitalization for Mental Illness - 30 day	42%	Lower
Follow-up Care for Children Prescribed ADHD Medication - Initiation	50%	Higher
Follow-up Care for Children Prescribed ADHD Medication - Continuation and Maintenance	63%	Higher
Frequency of Ongoing Prenatal Care - $\geq 81\%$ of expected visits	67%	Higher
Immunizations for Adolescents - Combo 1	67%	Lower
Initiation of Alcohol and Other Drug Dependence Treatment - 13-17 years of age	38%	Lower
Initiation of Alcohol and Other Drug Dependence Treatment - 18+ years of age	40%	Higher
Initiation of Alcohol and Other Drug Dependence Treatment - total	40%	Higher
Lead Screening in Children	61%	Lower
Medication Management for People with Asthma - 75% - total	30%	Lower
Timeliness of Prenatal Care	83%	Higher
Postpartum Care	59%	Lower
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass	62%	Lower

Index Assessment for Children/Adolescents - total		
Well-Child Visits in the First 15 Mos. - 0 Visits (INVERSE)*	2%	At the mean
Well-Child Visits in the First 15 Mos. - 6+ Visits	58%	Lower
Well-Child Visits 3-6 Years	75%	Higher

*For inverse measures, lower rates indicate better performance.

Table 7 lists the statewide weighted means for the non-HEDIS performance measures that were submitted for calendar year 2015.

Table 7 Calendar Year 2015 MMA Non-HEDIS Performance Measure Results	
Agency-Defined	CY 2015 Weighted Mean
Mental Health Readmission Rate (INVERSE)	27%
Transportation Timeliness	71%
Transportation Availability	100%
Highly Active Anti-Retroviral Treatment	65%
HIV-Related Outpatient Medical Visits - 0 visits	18%
HIV-Related Outpatient Medical Visits - 1 visit	15%
HIV-Related Outpatient Medical Visits - 2 visits (≥182 days)	28%
HIV-Related Outpatient Medical Visits - ≥ 2 visits	67%
Child Health Check-Up Report (CMS-416)	
Dental Treatment Services	15%
Sealants	13%
Child Core Set	
Preventive Dental Services	33%
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk	25%
HPV Vaccine for Female Adolescents	21%

Adult Core Set	
HIV Viral Load Suppression - 18-64 years	13%
HIV Viral Load Suppression - 65+ years	9%
Plan All-Cause Readmissions - 18-64 years - total	23%
Plan All-Cause Readmissions - 65+ years - total	11%

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. 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 minimum standards.

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 will be assigned according to the table below. Individual performance measures will be grouped and the scores averaged within each group.

PM Ranking	Score
>= 90th percentile	6
75th – 89th percentile	5
60th – 74th percentile	4
50th – 59th percentile	3
25th-49th percentile	2
10th – 24th percentile	1
< 10th percentile	0

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

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 (acute):
 - Follow-up Care for Children Prescribed ADHD Medication (initiation)
 - Follow-up after Hospitalization for Mental Illness (7 day)
 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (initiation – total)

- b. Well-Child
 - Adolescent Well Care Visits:
 - Childhood Immunization Status – Combo 3
 - Immunizations for Adolescents – Combo 1
 - Well-Child Visits in the First 15 Months of Life (6 or more)
 - Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
 - Lead Screening in Children

- c. Other Preventive Care:
 - Adults' Access to Preventive/Ambulatory Health Services (total)
 - Annual Dental Visits (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 (2) measures)
 - Frequency of Prenatal Care (\geq eighty-one percent (81%) of expected visits)

- 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
 - Medication Management for People with Asthma (50% - total)
 - Annual Monitoring for Patients on Persistent Medications (total)

The Agency may amend the performance measure groups with six 60 days' advance notice.

In addition, 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.

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 changed the methodology for performance measure liquidated damages effective with the August 15, 2016 SMMC contract amendment. The key provisions of the methodology are as follows:

- The Agency compares the MMA plan's performance measure rates to the NCQA HEDIS National Means and Percentiles for Medicaid plans. For each measure where the MMA plan's rate falls below the 50th percentile, the MMA plan may receive liquidated damages. Liquidated damages will be 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.
- For performance measures where the MMA plan's rate falls below the 50th percentile, liquidated damages may be assessed at \$100 per eligible member not receiving the service being measured up to the 50th percentile rate for the measure.
- 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 2014 being a transition year across contracts, no liquidated damages were assessed for performance measures. Beginning with the calendar year 2015 performance measures report, performance measure-related liquidated damages were assessed.

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
- Mental 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 three Report Cards. The current Medicaid Health Plan Report Card, published in October 2016, is based on HEDIS 2016 data (i.e., CY 2015 data reported in 2016) 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. Child Health Check-Up (CHCUP)

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.

1. CHCUP Sanctions

MMA plans, by Agency contract and state law, must achieve a child health check-up screening rate of at least eighty percent 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 screening 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 CHCUP (CMS-416) and FL 80% Screening Report that is due annually to the Agency. This requirement increased from sixty percent under the previous health plan contract to eighty percent under the MMA contract. For each federal fiscal year that the MMA plan does not achieve the eighty percent screening 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 eighty percent child health check-up participation rate. The 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 CHCUP (CMS-416) and Florida 80% Screening Report that is due

annually to the Agency. For each federal fiscal year that the MMA plan does not meet the eighty percent participation rate, the Agency may require a CAP to be submitted and may assess liquidated damages.

The MMA plan must also achieve a preventive dental services rate of at least twenty-eight percent for those enrollees who are continuously eligible for CHCUP for ninety continuous days. This rate is based on the CHCUP data reported by the MMA plan in its CHCUP (CMS-416) audited report that is due annually to the Agency. Beginning with the report for federal fiscal year 2015, failure to meet the 28% preventive dental services rate may result in a CAP and liquidated damages.

Table 8 displays FFY 2014-2015 MMA Plan-level 1 CHCUP/CMS-416 Report Metrics.

Table 8			
FFY 2014-2015 MMA Plan-Level CHCUP/CMS-416 Report Metrics			
Plan Name	Federal Participation Rate	Florida Screening Rate	Preventive Dental Services Rate
Amerigroup	73%	95%	34%
Better Health	76%	92%	33%
Clear Health	58%	70%	14%
Children's Medical Services	68%	73%	32%
Community Care Plan	77%	92%	34%
Coventry	81%	89%	31%
Humana	72%	100%	34%
Magellan	23%	25%	17%
Molina	73%	84%	40%
Positive	77%	81%	2%
Prestige	67%	81%	30%
Simply	78%	93%	38%
Staywell	71%	86%	37%
Sunshine	65%	80%	28%
United	67%	80%	31%

D. 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 2016, the required Adult Medicaid sample size was 1,350 and the Child Medicaid sample size was 1,650.

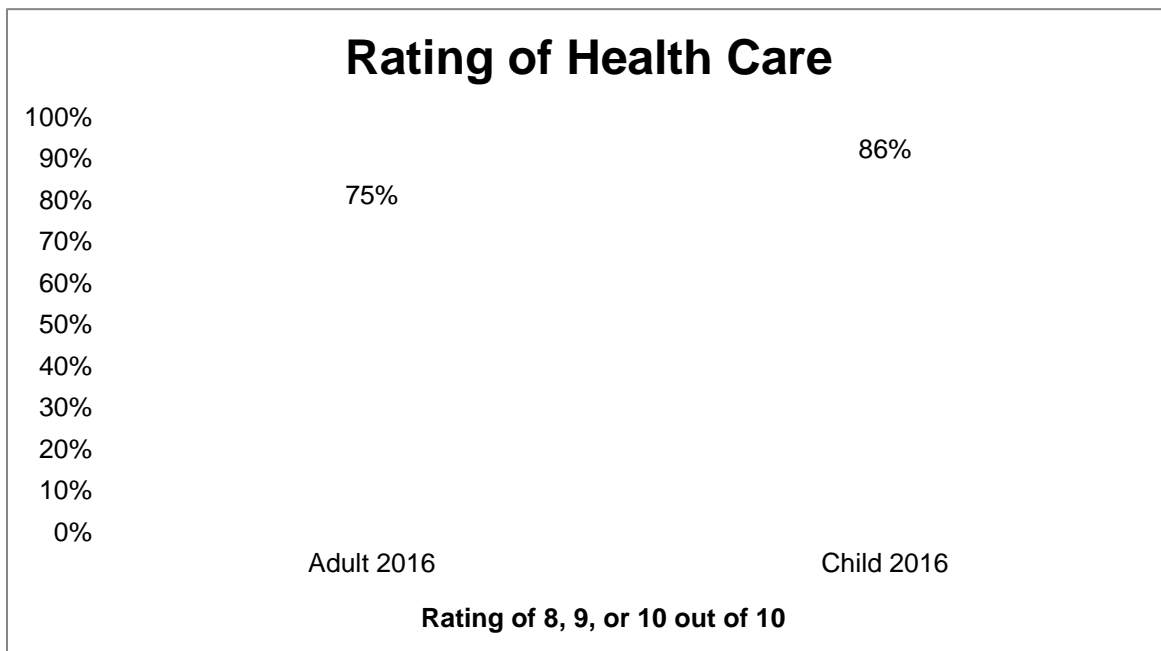
Plans are required to report their certified results to the Agency on an annual basis. Beginning with the 2016 survey, plans were also required to report their results to NCQA so they may be included in the National Medicaid Means and Percentiles. The results of these surveys are posted on the Agency's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

Rating of Health Plan

The CAHPS survey asks enrollees to rate their health plan on a scale from 0 to 10, with 0 being the worst plan possible and 10 being the best plan possible. In the 2016 MMA survey, 73% of adults gave their health plans ratings of 8 to 10. Among parents of children enrolled in MMA plans, 84% rated their children's plans an 8, 9, or 10 out of 10.

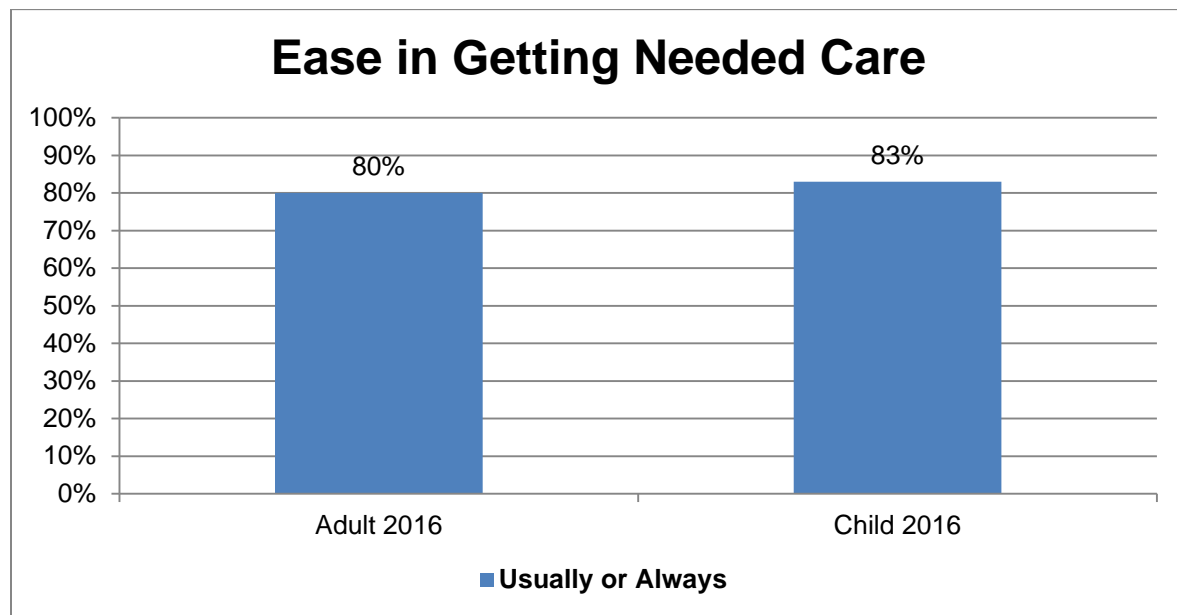
Rating of Health Care

CAHPS survey respondents are asked to rate their health care on a scale of 0 to 10, with 0 being the worst care possible and 10 being the best health care possible. In 2016, 75% of adults in the MMA plans rated their health care an 8, 9, or 10. In the 2016 child surveys, 86% of parents rated their children's health care an 8, 9, or 10.



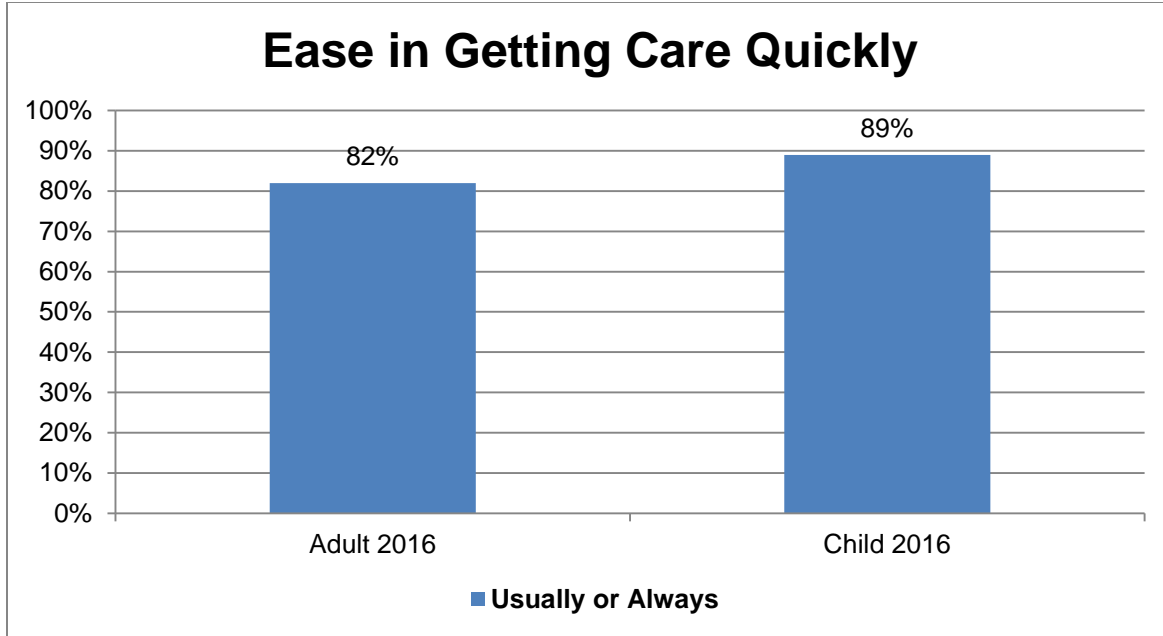
Getting Needed Care and Getting Care Quickly

CAHPS survey respondents are asked about ease of getting specialist appointments and getting care, tests, or treatment they need through the respondent's health plan. These two survey items ask how often the respondent got an appointment to see a specialist as soon as he/she needed and how often it was easy to get the care, tests or treatment he/she needed. The response categories for these items are Never, Sometimes, Usually, and Always. A composite called "Ease in Getting Needed Care" averages the responses for these two survey items. In the 2016 adult surveys, 80% of adults reported it was usually or always easy to get needed care while in the 2016 child surveys, 83% of parents reported that it was usually or always easy to get needed care for their children.



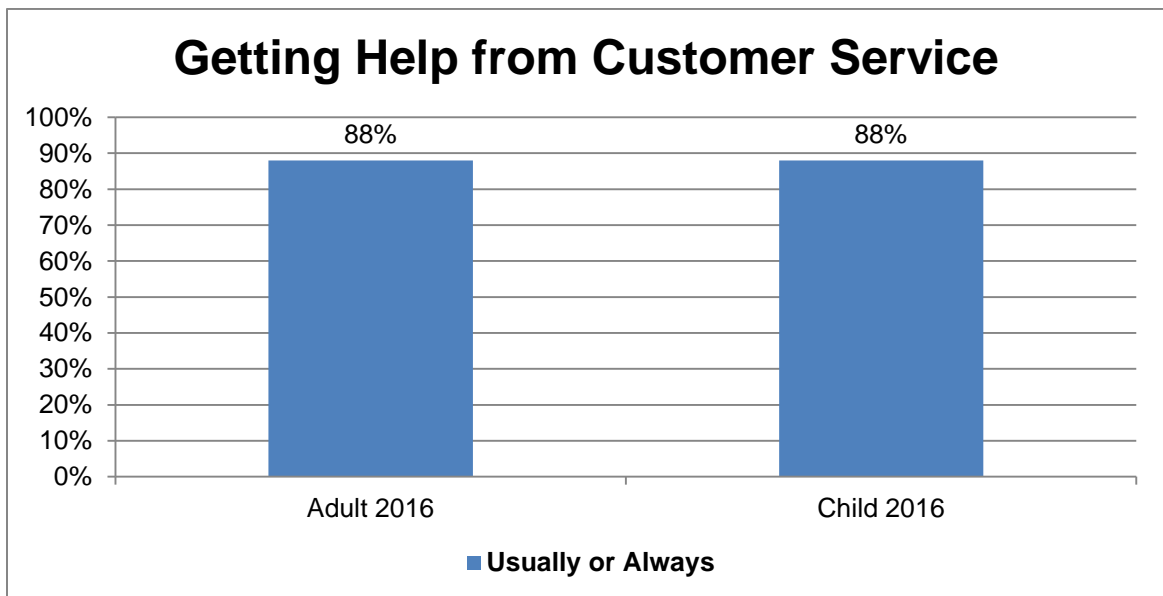
Getting Care Quickly

CAHPS survey respondents are asked about how often they received care as soon as they needed it in both urgent and non-urgent/routine situations. The two survey items are averaged to make a composite score. The response categories for these items are Never, Sometimes, Usually, and Always. In the surveys of adults, 82% in 2016 reported that it was usually or always easy to get care as soon as they needed it. In the child surveys, 89% of parents reported that it was usually or always easy to get care as soon as their children needed it in 2016.



Getting Help from Customer Service:

CAHPS survey respondents are asked how often their health plan’s customer service gave them the information or help they needed and how often the customer service staff treated them with courtesy and respect. The response categories for these two items are Never, Sometimes, Usually, and Always. The responses to the two items are averaged into one composite score. In the 2016 surveys, 88% of adults and 88% of parents reported that they usually or always received the information and help they needed from their children’s plan’s customer service.



III. Long-term Care

A. Required Performance Measures

Table 9 provides the list of performance measures the Long-term Care (LTC) health plans were required to report to the Agency on July 1, 2016, for calendar year 2015.

Table 9	
LTC Required Performance Measures	
HEDIS/Agency-Defined	
1	Care for Older Adults (COA): - included components: advance care planning; medication review; and functional status assessment. Add age bands: <ul style="list-style-type: none"> • 18 to 60 years as of December 31 of the measurement year* • 61 to 65 years as of December 31 of the measurement year* • 66 years and older as of December 31 of the measurement year
Agency-Defined	
2	Required Record Documentation (RRD)
3	Face-to-Face Encounters (F2F)
4	Case Manager Training (CMT)
5	Timeliness of Services (TOS)
6	Prevalence of Antipsychotic Drug Use in Long-Stay Dementia Residents

*Agency addition to HEDIS

The LTC performance measures are Agency-defined and the specifications have been modified over the past couple of years to better align with LTC plan contractual requirements and expectations. Calendar year 2015 data should be used as a baseline for LTC performance.

Table 10 lists the statewide weighted means for the calendar year 2015 performance measures.

Table 10 Calendar Year 2015 LTC Performance Measure Results	
Measure	CY 2015 Weighted Mean
Care for Older Adults - Advance Care Planning - Total	42%
Care for Older Adults - Functional Status Assessment - Total	85%
Care for Older Adults - Medication Review - Total	34%
Case Manager Training	94%
Face-to-Face Encounters	90%
Required Record Documentation - 701B Assessment	80%
Required Record Documentation - Care Plan - Enrollee Participation	70%
Required Record Documentation - Care Plan - PCP Notification	54%
Required Record Documentation - Freedom of Choice Form	69%
Timeliness of Service	58%

1. Performance Measure Sanctions

The Agency may sanction LTC plans for failure to achieve minimum scores on performance measures specified by the Agency after the first year of poor performance. The HEDIS measures are compared annually to the NCQA HEDIS National Means and Percentiles. The Agency-defined measures have threshold rates (percentages) that may trigger a sanction. The survey-based measures have threshold average ratings (from 0-10) that may trigger a sanction.

Table 11 Performance Measure Sanction Table – Effective 8/01/2013 – 8/31/2018	
HEDIS Measures	Rate and applicable sanction
Care for Older Adults	Rate < 25th percentile - immediate monetary sanction and PMAP may be imposed Rate < 50th percentile - PMAP may be required
Agency-Defined Measures	Rate and applicable sanction
Required Record Documentation - numerators 1-4	Rate < 85% - immediate monetary sanction

Face-to-Face Encounters	and PMAP may be imposed Rate < 90% - PMAP may be required
Care Manager Training	
Timeliness of Service	
Survey-based Measures	Average rating and applicable sanction
Satisfaction with Long-term Care Plan	Rate 4.0 or lower – immediate monetary sanction and PMAP may be imposed
Satisfaction with Care Manager	
Rating of Quality of Services	Rate 5.0 or lower – PMAP may be required

LTC plans may receive a monetary sanction for measures for which their scores do not meet the thresholds given in the above table 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. For the HEDIS and Agency-defined measures, if the plan has a score/rate that triggers an immediate monetary sanction, the plan may be sanctioned \$500 for each case in the denominator not present in the numerator. If the plan fails to improve these performance measures in subsequent years, the Agency will impose a sanction of \$1,000 per case. For each survey-based measure in the table above for which the plan has an average rate that triggers an immediate monetary sanction, the plan may be sanctioned \$10,000.

2. Performance Measure Liquidated Damages

The Agency compares the LTC plans’ HEDIS performance measure rates to the NCQA HEDIS National Means and Percentiles for Medicare plans. For Agency-defined and survey-based measures, the Agency compares to the established thresholds. The liquidated damages thresholds and amounts are outlined in Table 12 below.

Table 12 LTC Performance Measure Liquidated Damages Amounts	
Care for Older Adults	<p>Failure to achieve a rate at the 25th percentile (per the NCQA National Means and Percentiles, Medicare) or higher will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure.</p> <p>If the Managed Care Plan’s rate remains below the 25th percentile in subsequent years, damages will be \$1,000 per case.</p>

Required Record Documentation - numerators 1-4	<p>Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure.</p> <p>If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.</p>
Face-to-Face Encounters	<p>Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure.</p> <p>If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.</p>
Care Manager Training	<p>Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure.</p> <p>If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.</p>
Timeliness of Service	<p>Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure.</p> <p>If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.</p>
Satisfaction with Care Manager and LTC Managed Care Plan	<p>Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure.</p> <p>If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.</p>
Rating of Quality of Services	<p>Failure to achieve a rate of 90% or higher for each of these measures will result in liquidated damages of \$500 per each case in the denominator not present in the numerator for the measure.</p> <p>If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be \$1,000 per case.</p>

The Agency is in the process of adapting the LTC performance measure liquidated damages methodology to better align with the liquidated damages methodology for the MMA performance measures.

B. LTC Enrollee Satisfaction Survey

The LTC plans are required to conduct an annual enrollee satisfaction survey using the Enrollee Survey for Long-term Care plans and following the Survey Administration Guidelines created by the Agency. This confidential survey assesses experience with care for LTC enrollees residing in the community. The third LTC enrollee satisfaction survey (fielded in spring 2016) and subsequent submissions are due to the Agency by July 1 of each year.

LTC plans are required to contract with an Agency-approved independent survey vendor to administer the surveys with a minimum sample size of 1,700 and a target of 411 completed surveys. The survey must be administered according to the NCQA mixed mode protocol (mail with telephone follow-up). LTC plans are required to use the core LTC Plan Enrollee 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 LTC plan for at least six months with no more than a one-month gap in enrollment. Enrollees can have someone help them fill out the survey if needed.

Table 13 lists the 2016 statewide LTC enrollee survey results.

Survey Measure	Statewide Rate
LTC Plan Rating (% rating plan an 8, 9, or 10 on a 0-10 scale)	78%
Contacting Case Manager (% reporting usually or always easy)	80%
Case Manager Rating (% rating case manager an 8, 9, or 10 on a 0-10 scale)	81%
Timeliness of Services (% reporting usually or always on time)	89%
LTC Services Rating (% rating LTC services an 8, 9, or 10 on a 0-10 scale)	80%
Overall Health - Improved Since Enrolled in LTC Plan	60%
Quality of Life - Improved Since Enrolled in LTC Plan	76%

IV. 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. A prepaid plan has an obligation to cooperate in good faith with the Agency and the certified public accountant and failure to comply with records requests made by the Agency will be deemed a breach of contract.

The independent auditor will determine the achieved savings of each plan. This includes the incentive that a plan that exceeds Agency-defined quality measure benchmarks in the reporting period may retain an additional one percent of revenue. In order to retain the one percent incentive, plans must achieve a group score of four or higher for each of the six performance measure groups in the first year of reporting performance measures. To be eligible to retain an additional one percent of revenue based on the second year and subsequent years of reporting performance measures, the managed care plan must achieve a group score of five or higher for each of the six performance measure groups.

For MMA plans, the Agency assigns the HEDIS performance measures listed below 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 the scores averaged within each group.

PM Ranking	Score
$\geq 90^{\text{th}}$ percentile	6
$75^{\text{th}} - 89^{\text{th}}$ percentile	5
$60^{\text{th}} - 74^{\text{th}}$ percentile	4
$50^{\text{th}} - 59^{\text{th}}$ percentile	3
$25^{\text{th}} - 49^{\text{th}}$ percentile	2
$10^{\text{th}} - 24^{\text{th}}$ percentile	1
$< 10^{\text{th}}$ percentile	0

Performance measure groups are as follows:

A. Mental Health and Substance Abuse:

- Antidepressant Medication Management (acute)
- Follow-up Care for Children Prescribed ADHD Medication (initiation)
- Follow-up after Hospitalization for Mental Illness (7 day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (initiation – total)

B. Well-Child:

- Adolescent Well Care Visits
- Childhood Immunization Status – Combo 3
- Immunizations for Adolescents – Combo 1
- Well-Child Visits in the First 15 Months of Life (6 or more)
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Lead Screening in Children

C. Other Preventive Care:

- Adults' Access to Preventive/Ambulatory Health Services (total)
- Annual Dental Visits (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 (2) measures)
- Frequency of Prenatal Care (\geq eighty-one percent (81%) of expected visits)

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
- Medication Management for People with Asthma (50% - total)
- Annual Monitoring for Patients on Persistent Medications (total)

In order to be eligible to retain up to an additional one percent of revenue in the first year, a Comprehensive plan must exceed the specified threshold for each and all performance measures as listed below:

Measure	Threshold
<u>HEDIS Measures</u>	
Care for Older Adults	90 th percentile
Call Answer Timeliness	90 th percentile
<u>Agency-Defined</u>	
Required Record Documentation	
• 701B Assessment	95%
• Freedom of Choice Form	95%
• Plan of Care/Enrollee Participation	95%
• Plan of Care/PCP Notification	95%
Face-To-Face Encounters	95%
Case Manager Training	95%
Timeliness of Services	98%

Comprehensive plans that meet the quality standards for only one program component (LTC or MMA), may retain up to one percent of achieved savings rebate-allowed revenue associated with the component for which they meet the quality standards. To date no plans have earned the achieved savings rebate for exceptional quality.

SEE SEPARATE EXCEL SPREADSHEET for APPENDIX 3:

**CROSSWALK BETWEEN MINIMUM ELEMENTS of CMS's STATE QUALITY STRATEGY and
FLORIDA'S CQS REPORT**