Florida Medicaid

Managed Medical Assistance Waiver

1115 Research and Demonstration Waiver
#11-W-00206/4

Annual Report

July 1, 2018 – June 30, 2019
Demonstration Year 13

Agency for Health Care Administration

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Executive Summary

Managed Medical Assistance Program Overview

The Managed Medical Assistance (MMA) program is one component of the Statewide Medicaid Managed Care (SMMC) program. A version of the MMA program was initially approved by the Centers for Medicare and Medicaid Services (CMS) as a pilot program in 2005, under the 1115 Research and Demonstration Waiver authority. In 2014, CMS approved the renewal for the MMA 1115 Research and Demonstration Waiver, and the MMA program rolled out statewide.

The State is required to submit an Annual Report at the end of each Waiver Demonstration Year. This report summarizes events that occurred throughout the year and affected the health care delivery system. Additionally, the report outlines future events, anticipated to occur, that will also affect the health care delivery system moving forward. This Annual Report is for Waiver Demonstration Year 13 (DY13) covering July 1, 2018, through June 30, 2019.

Additional detailed information, regarding previous waiver activities and reports, is available under the State's Quarterly and Annual Reports section of the Agency for Health Care Administration's website: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/mma_fed_auth.shtml.

The MMA program improves health outcomes for Florida Medicaid recipients while maintaining fiscal responsibility. This is achieved through care coordination, patient engagement in their health care, enhancing fiscal predictability and financial management, improving access to coordinated care, and improving overall program performance.

Health Care Plan Contract Procurement

The SMMC program began in 2013, with 5-year contracts awarded to Managed Care Plans; these contracts were set to expire in 2018. Thus, Florida's first SMMC plan re-procurement effort began in 2017. The contracts resulting from the re-procurement had an effective date in December 2018.

There are five different SMMC program plan types for the contracts effective 2018 through 2023, all of which fall into one of the following classifications:

1. **Comprehensive Plans**: Provides MMA services and Long-Term Care (LTC) services to eligible recipients.
2. **Long-Term Care Plus Plans**: Provides MMA services and LTC services to recipients enrolled in the LTC program. This plan type cannot provide services to recipients who are only eligible for MMA services.
3. **Managed Medical Assistance Plans**: Provides MMA services to eligible recipients. This plan type cannot provide services to recipients who are eligible for LTC services.
4. **Specialty Plans**: Provides MMA services to eligible recipients who qualify as a member to a specialty population.
5. **Dental Plans**: Provides preventive and therapeutic dental services to all recipients in managed care and all fully eligible fee-for-service individuals.

The Agency made significant gains during contract negotiations, both for recipients and providers. For example, recipients' access to care expanded by doubling the number of primary care providers available in each network, guaranteeing patients' access to after-hours care, the use of telemedicine, and the addition of 55 expanded benefit services. Some of the new benefits for service providers include an expedited credentialing process, which must be completed by the MMA plans within 60 days, and a waiver of prior authorization requirements for high performing providers.

Expanded Benefits

MMA health and dental plans now offer many additional expanded benefits to their enrollees. Expanded benefits are services covered by the MMA plans beyond the mandatory services contained in the Medicaid State Plan. The health and dental plans pay for the expanded benefits, thus there is no additional cost to the State for these services.

Attachment I provides a comprehensive list of all the expanded benefit services health and dental plans may choose to cover, as well as the regional implementation schedule for the newly awarded contracts. Plans are not required to offer all of the expanded benefits contained in Attachment I; each plan distributes their list of covered expanded benefit service options, along

with information regarding prior authorization requirements, to each of their enrollees via the Enrollee Handbook.

The addition of expanded benefit services, such as additional home health nursing visits, transportation services, home delivered meals, physical therapy, and housing assistance, which includes grocery assistance, supports the Agency's goal of increasing the percentage of individuals able to receive services in their homes and within their communities, instead of being institutionalized.

There are also a number of additional substance abuse, mental health, and behavioral health treatment services now available to recipients through the expanded benefits packages. These services range from screening/evaluation and case management to intensive outpatient services including alternative pain management services.

The expanded benefits package, achieved through the re- procurement cycle, has made vast improvements to the Medicaid delivery system. They have broadened the array of services available to Medicaid recipients and enhanced recipient access to care.

Enhanced Quality and Health Outcomes

During the re-procurement process, each of the MMA plans committed to higher performance goals. The health plans committed to reducing potentially preventable admissions, readmissions, and emergency department visits as well as reducing primary C-section rates, pre-term deliveries, and the number of babies born with neonatal abstinence syndrome.

Similarly, the dental plans have committed to decreasing the dental emergency department visit rate, while increasing annual visits and preventive dental care visit rates.

The chart below details the health and dental plans' commitments for the new 5-year contract period.

Health Plans		**Dental Plans**	
Avg. Reduction	**Quality Outcome**	**Avg. Yearly Increase**	**Service Type**
22%	Preventable Admissions	3%	Annual Dental Visits-Above the Annual ITN Target
21%	Preventable Re-admissions	1%	Preventive Dental Care-Above the annual ITN Target
14%	Preventable Emergency Department Visits	**Reduction**	**Potentially Preventable Event**
12%	Primary C-section Rate	5%	Dental related emergency department visits within the first year
10%	Pre-term Deliveries	9%	Emergency Department Visits within the 5-year contract
15%	Babies Born with Neonatal Abstinence Syndrome		

Telehealth

Florida has adopted the use of telehealth, or telemedicine, technology to increase recipient access to health care practitioners and to help care become more convenient to access. The new Florida Medicaid contracts require MMA plans to reimburse network providers for covered services provided via telehealth technology.

Dental Program

The Agency submitted an amendment to the MMA Waiver in order to implement a separate dental managed care program for Florida Medicaid recipients. The Centers for Medicare and Medicaid Services (CMS) approved the amendment with an effective date of December 1, 2018. The State implemented this program in three at the same time the MMA contracts went live.

Through contracted dental plans, Florida Medicaid now covers preventive and therapeutic dental services to all recipients enrolled in managed care as well as for all fully eligible fee-for-service individuals. An important gain for adult recipients was the addition of expanded benefits offered through the dental managed care plans. These services include but are not limited to preventive, diagnostic and restorative care services, including periodontics, oral, maxillofacial surgery, and diabetic testing. Previously, adults in Florida Medicaid only received dental services related to dentures, and emergency services to relieve pain and infection.

Section I: Operational Updates

Agency Contracting Activities

Plan Contracting Status

The Agency recently entered into new contracts with health and dental managed care plans, which greatly benefited enrollees and providers. Under the new SMMC contracts, the Agency focused on fully integrating health care. As such, health plans are responsible for covering services previously covered under the fee-for-service program. These services include:

- Early Intervention Services
- Medical Foster Care
- Short-Term Nursing Facility Services
- Child Health Services Targeted Case Management

Additionally, all managed care plans participating in the SMMC program offer enhanced expanded benefit packages, which focus on a variety of areas such as substance abuse, mental health treatment, and alternative pain management services. The services provided under the expanded benefit packages have largely increased, and are covered under the MMA plans at no additional charge to the State. Each plan has a unique offering of expanded benefits they cover, as they are not required to provide all of the services enumerated on the comprehensive list contained in **Attachment I**. Information regarding the particulars of each expanded benefit service, including prior authorization, is provided to recipients in the Enrollee Handbook. Each plan has also doubled the number of primary care physicians available in their networks and embraced the use of telehealth, or telemedicine, which expands recipient access to after-hours care and health specialists.

The new SMMC contracts went into effect in December of 2018 and are set to expire on December 31, 2023. The contracts awarded include:

- **7 Comprehensive Plans** – MMA services and LTC services
- **1 Long-Term Care (LTC) Plus Plan** – MMA services and LTC services (MMA only recipients are not eligible for this plan)
- **4 MMA-Only Plans** – MMA services (LTC recipients are not eligible for this plan)
- **5 Specialty Plans** – MMA services to recipients who qualify under a specialty population
- **3 Dental Plans -** Provide preventive and therapeutic dental services to all MMA recipients and all fully eligible fee-for-service individuals

Information pertaining to the specific Health and Dental Plans awarded contracts for the 2018-2023 contract term are on the following pages.

Plan Types
Comprehensive Plans
Long-Term Care Plus Plans
Managed Medical Assistance Plans
Specialty Plans
Dental Plans

SMMC Participating Health and Dental Plans	
Known as:	**Full Business Name:**
Aetna	Coventry Health Care of Florida D/B/A/ Aetna Better Health of Florida
Humana	Humana Medical Plan
Molina	Molina Health Care of Florida
Simply	Simply Healthcare Plan **(Formerly Amerigroup and Better Health)**
Staywell	Wellcare of Florida D/B/A Staywell Health Plan of Florida
Sunshine	Sunshine State Health Plan
United	United Health Care of Florida
FCC	Florida Community Care
Vivida	Best Care Assurance D/B/A Vivida Health
Prestige	Florida True Health D/B/A/ Prestige Health Choice
CCP	SFCCN D/B/A Community Care Plan
Lighthouse	Lighthouse Health Plan
Miami Children's	Miami Children's Health Plan
Sunshine - Child Welfare Specialty Plan	Sunshine - Child Welfare Specialty Plan
Children's Medical Services Network	Children's Medical Services Network
Clear Health Alliance- HIV/AIDs Specialty Plan	Clear Health Alliance- HIV/AIDs Specialty Plan
Staywell- Serious Mental Illness Specialty Plan	Staywell- Serious Mental Illness Specialty Plan
MCNA	Managed Care of North America
DentaQuest	DentaQuest of Florida
Liberty	Liberty Dental Plan of Florida

All Medicaid recipients receiving MMA services are now eligible to select a dental managed care plan for preventive and therapeutic dental services. The inclusion of dental managed care plans in the MMA program was accomplished through an amendment to the MMA Waiver. The dental plan amendment was approved, and made effective by CMS in December 2018. The State implemented the new MMA plan contracts and dental program in three phases:

Implementation Schedule			
	Transition Date	**Regions Included**	**Counties within the Region**
Phase 1	December 1, 2018	9	Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
		10	Broward
		11	Miami-Dade, Monroe
Phase 2	January 1, 2019	5	Pasco, Pinellas
		6	Hardee, Highlands, Hillsborough, Manatee, Polk
		7	Bevard, Orange, Osceola, Seminole
		8	Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota
Phase 3	February 1, 2019	1	Escambia, Okaloosa, Santa Rosa, Walton
		2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington
		3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union,
		4	Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia

Contract Amendments

The Agency finalized one MMA plan general contract amendment for plans operating under the previous 2013-2018 contract during DY13.

1. In December 2018, the Agency executed a contract amendment to identify reporting requirements that would survive the MMA contract after its December 2018 expiration date. Specifically, this amendment altered the capitation rates for the remainder of the contract term, revised the contract end dates to align with the implementation of the new contracts, and incorporated contract provisions to designate deliverables that would survive the end of the contract (e.g., financial reporting, performance measures, encounter data, etc.).

In April 2019, the Agency published a revised Statewide Medicaid Managed Care Managed Care Plan Report Guide; this revision included the addition of two chapters:

1. Service Authorization Outcome Report
2. Medical Foster Care Services Report

The revision also included miscellaneous revisions to other report templates in order to clarify instructions, correct formulas, and make technical corrections.

In DY13, the Agency began work on the MMA contracts resulting from the procurement process. Examples of substantive changes made to the MMA contracts during DY13 include:

- Transitioning Medicaid Fair Hearings for SMMC enrollees to the Agency from the Florida Department of Children and Families,
- Incorporating provisions from the Managed Care Final Rule (42 CFR 438),
- Incorporating subcontract elements per federal requirements (42 CFR 438),
- Adding subcontractor records retention requirements per federal regulations (42 CFR 438),
- Revising the Medicaid Physician Incentive Program reporting requirements, and
- Broadened the array of the expanded benefits available to Medicaid recipients through the MMA plans.

The Model Contracts for both health and dental plans are available on the Agency's website: http://ahca.myflorida.com/SMMC

Communication to the MMA Plans

During DY13, the Agency released a total of 20 policy transmittals and 6 contract interpretations:

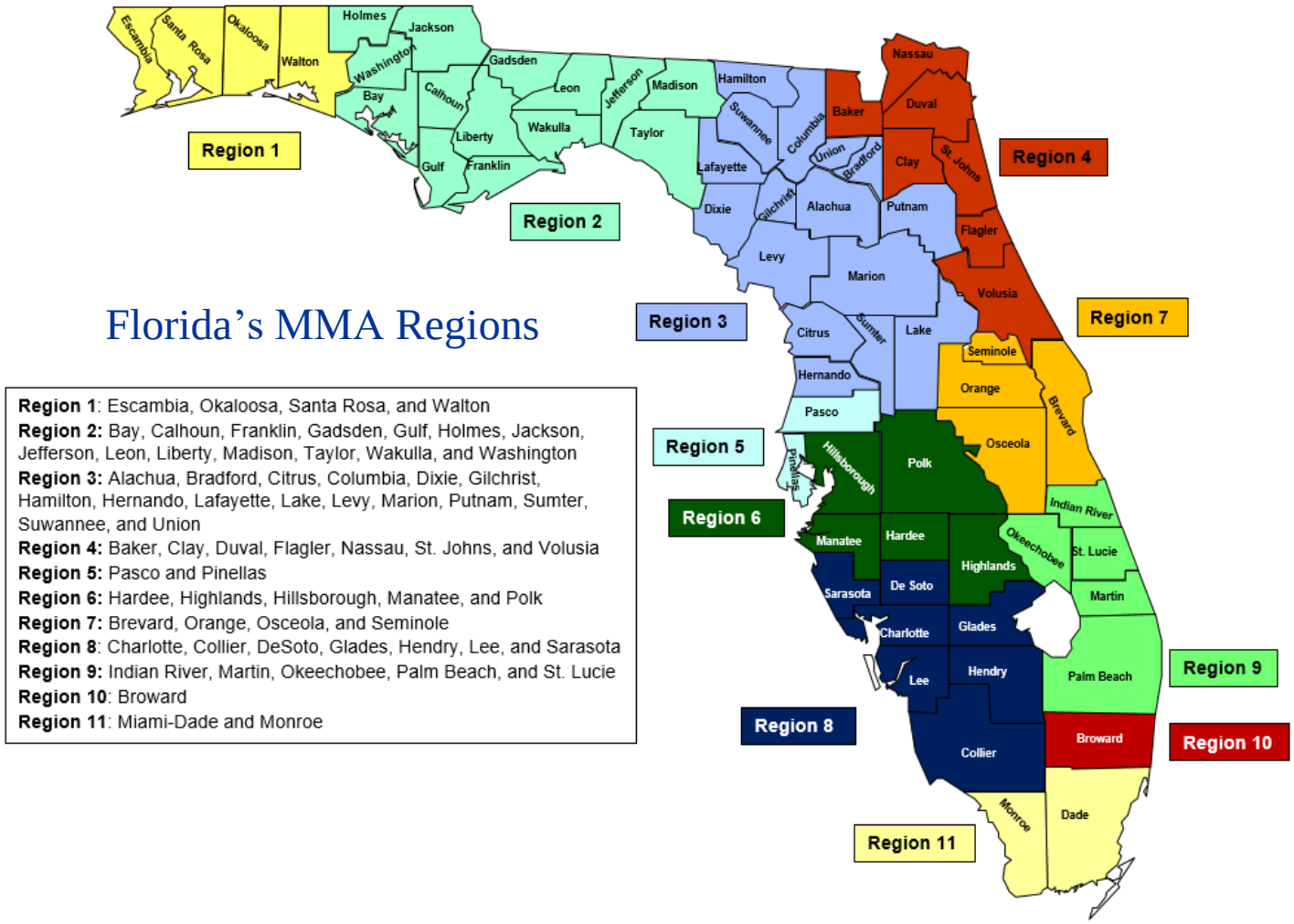
2013-2018 SMMC Contracts
- 6 policy transmittals
- 1 contact interpretation

2018-2023 SMMC Contracts
- 13 policy transmittals
- 5 contract interpretations

Examples of Policy Transmittal Topics include:
- Ad hoc reporting requests
- Changes to reporting templates
- New coverage requirements
- Revised reporting requirements

A complete listing of the Agency's communications to the MMA plans is available on the Agency's website: http://ahca.myflorida.com/SMMC.

Florida Medicaid Regions and the New MMA Plan Options (Contract years 2018 – 2023)



Health Plans by Region

REGION	AETNA BETTER HEALTH	COMMUNITY CARE PLAN	FLORIDA COMMUNITY CARE	HUMANA MEDICAL PLAN	LIGHTHOUSE HEALTH PLAN	MIAMI CHILDREN'S	MOLINA HEALTHCARE	PRESTIGE	SIMPLY HEALTHCARE	STAYWELL	SUNSHINE HEALTH	UNITEDHEALTHCARE	VIVIDA HEALTH
1			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP	LIGHTHOUSE HEALTH PLAN MMA					STAYWELL COMP	SUNSHINE HEALTH COMP		
2			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP	LIGHTHOUSE HEALTH PLAN MMA					STAYWELL COMP	SUNSHINE HEALTH COMP		
3			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP						STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
4			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP						STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
5			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP		
6	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	
7	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP		
8			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP			MOLINA HEALTHCARE COMP			STAYWELL COMP	SUNSHINE HEALTH COMP		VIVIDA HEALTH MMA
9			FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP		MIAMI CHILDREN'S MMA		PRESTIGE MMA		STAYWELL COMP	SUNSHINE HEALTH COMP		
10		COMMUNITY CARE PLAN MMA	FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP					SIMPLY HEALTHCARE COMP		SUNSHINE HEALTH COMP		
11	AETNA BETTER HEALTH COMP		FLORIDA COMMUNITY CARE LTC+	HUMANA MEDICAL PLAN COMP		MIAMI CHILDREN'S MMA	MOLINA HEALTHCARE COMP	PRESTIGE MMA	SIMPLY HEALTHCARE COMP	STAYWELL COMP	SUNSHINE HEALTH COMP	UNITEDHEALTHCARE COMP	

	Specialty Plans					Dental Plans		
REGION	CHILDREN'S MEDICAL SERVICES PLAN – CHILDREN WITH CHRONIC CONDITIONS	CLEAR HEALTH ALLIANCE – HIV/AIDS	MAGELLAN COMPLETE CARE – SERIOUS MENTAL ILLNESS (SMI)	STAYWELL – SERIOUS MENTAL ILLNESS (SMI)	SUNSHINE HEALTH – CHILD WELFARE	DENTAQUEST	LIBERTY	MCNA DENTAL
1	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
2	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
3	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
4	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
5	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
6	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
7	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC	MAGELLAN COMPLETE CARE SPEC	STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
8	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
9	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN
10	CHILDREN'S MEDICAL SERVICES PLAN SPEC	CLEAR HEALTH ALLIANCE SPEC		STAYWELL SPEC	SUNSHINE HEALTH SPEC	DENTAQUEST DEN	LIBERTY DEN	MCNA DENTAL DEN

MMA Plan Outreach

The MMA program facilitates outreach and informational opportunities for Florida Medicaid recipients. During the reporting period, plans either sponsored, co-sponsored, or participated in 2,398 events.

There are three types of events: public, educational, and marketing. The table below details the events held by each MMA plan:

Public, Educational, and Marketing Events Held by the MMA Plans

MMA Plan	Marketing Events	Public Events	Educational Events	*Total*
Best Care Assurance, LLC/Vivida Health	220	44	0	***264***
Florida Department of Health Children's Medical Services	0	0	0	***0***
Coventry Health Care of Florida, Inc./Aetna Better Health of Florida	6	26	0	***32***
Dentaquest of Florida, Inc.	0	15	4	***19***
Florida Community Care, LLC	45	6	0	***51***
Humana Medical Plan, Inc.	0	154	1	***155***
Lighthouse Health Plan	302	62	14	***378***
Liberty Dental Plan of Florida, Inc.	0	0	0	***0***
Managed Care Plan of North America, Inc.	0	36	0	***36***
Florida MHS, Inc./Magellan Complete Care	14	9	0	***23***
Miami Children's Health Plan, Inc.	212	27	6	***245***
Molina Health Care of Florida, Inc.	26	6	2	***34***
South Florida Community Care Network, LLC/ Community Care Plan	0	20	0	***20***
Florida True Health Inc./Prestige Health Choice	0	2	1	***3***
Simply Healthcare Plans, Inc.	363	91	0	***454***
Wellcare of Florida Inc./Staywell Health Plan of Florida Inc.	570	4	0	***574***
Sunshine State Health Plan, Inc.	33	37	0	***70***
United Health Care of Florida, Inc.	17	14	0	***31***
Total	***1,808***	***553***	***28***	***2,389***

MMA plans also produce and distribute marketing materials, which must be submitted to the Agency for approval prior to distribution. There are four marketing material categories:

- **Branding:** Marketing through mass communication in some form of print media, such as newspapers, magazines, billboards, etc., with the purpose of influencing a potential enrollee to enroll and to contact the managed care plan for more information.
- **Nominal gifts:** An individual item or service worth fifteen dollars or less (based on the retail value of the item), with a maximum aggregate of seventy-five dollars per person, per year that is given away at events.
- **Scripts:** Written text of messages transferred or transmitted to a large group of people by managed care plan staff through a form of mass communication media, such as television, radio, or social networking. These messages are designed to promote the managed care plan and influence individuals to enroll in the managed care plan. Scripts also include the standardized text used by managed care plan staff in verbal interactions with potential enrollees designed to provide information and/or to respond to questions and requests, and that are intended to influence such individual to enroll in the managed care plan. Additionally, marketing scripts include any text included in interactive voice recognition (IVR) and on-hold messages.
- **Written:** Printed informational material targeted to potential enrollees, which promotes the managed care plan, including, but not limited to brochures, flyers, leaflets or other printed information about the managed care plan. Written marketing material includes materials for circulation by physicians, other providers, or third parties.

The table on the following page details the types of materials submitted by the MMA plans, which were approved by the Agency.

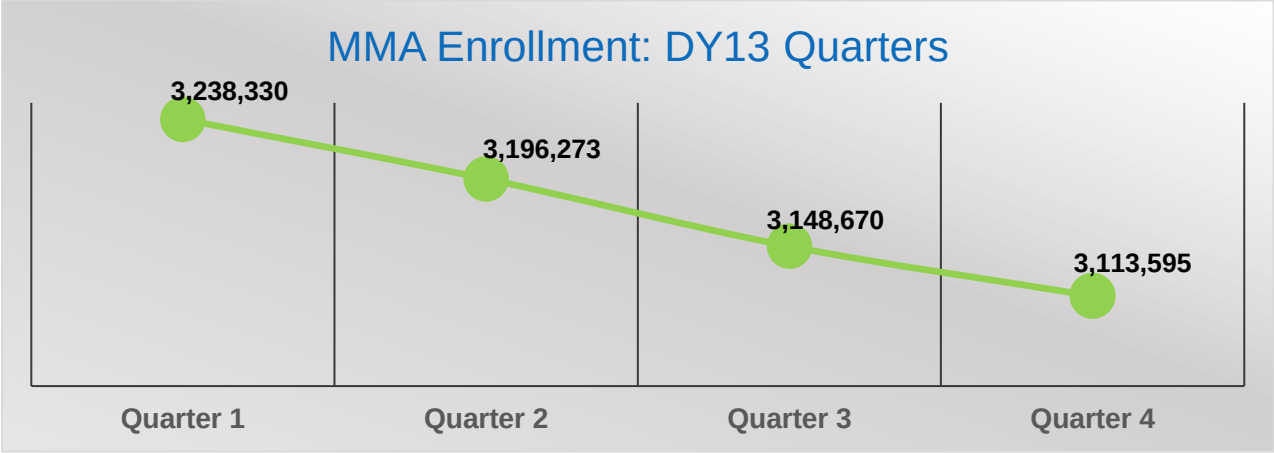
Materials Submitted to the Agency by the MMA Plans

MMA Plan	Branding	Nominal Gifts	Scripts	Written	*Total*
Best Care Assurance, LLC/Vivida Health	12	70	15	14	***111***
Florida Department of Health Children's Medical Services	0	9	0	0	***9***
Coventry Health Care of Florida, Inc./Aetna Better Health of Florida	16	21	4	6	***47***
Dentaquest of Florida, Inc.	2	4	3	2	***11***
Florida Community Care, LLC	3	15	5	7	***30***
Humana Medical Plan, Inc.	4	64	26	20	***114***
Lighthouse Health Plan	2	49	15	15	***81***
Liberty Dental Plan of Florida, Inc.	0	13	10	6	***29***
Managed Care Plan of North America, Inc.	0	12	0	0	***12***
Florida MHS, Inc./Magellan Complete Care	0	13	0	0	***13***
Miami Children′s Health Plan, Inc.	1	35	8	17	***61***
Molina Health Care of Florida, Inc.	0	33	1	6	***40***
South Florida Community Care Network, LLC/ Community Care Plan	42	30	0	0	***72***
Florida True Health Inc./Prestige Health Choice	0	3	0	0	***3***
Simply Healthcare Plans, Inc.	65	67	19	22	***173***
Wellcare of Florida Inc./Staywell Health Plan of Florida Inc.	1	105	2	32	***140***
Sunshine State Health Plan, Inc.	9	97	1	7	***114***
United Health Care of Florida, Inc.	0	113	1	2	***116***
Total	***157***	***753***	***110***	***156***	***1,176***

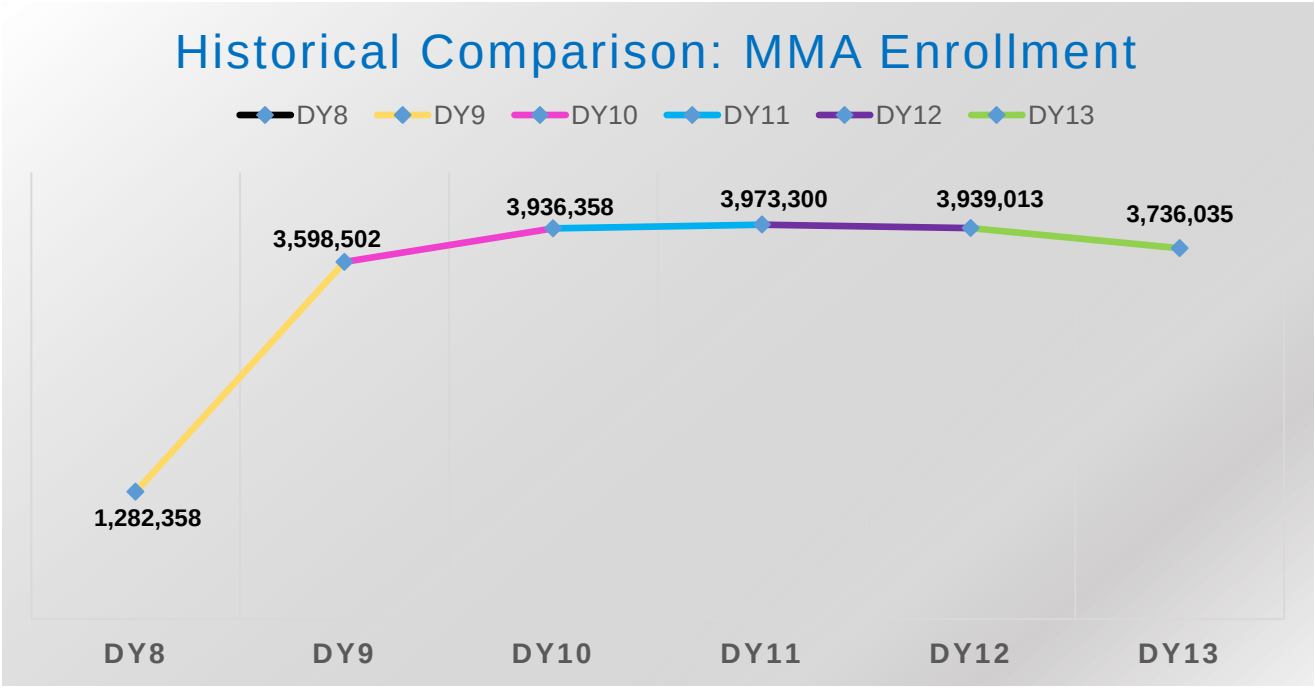
Enrollment and Disenrollment

Managed Medical Assistance Enrollment

Upon determination that an individual is eligible for Florida Medicaid, and that they are in an enrollment group designated as mandatory for managed care enrollment, the State of Florida immediately enrolls them into an MMA plan. This enrollment process provides the individual immediate access to care, through an integrated delivery system, as well as access to any of the expanded benefits available through their MMA plan. The following graph illustrates DY13 enrollment, which shows a slight decline in enrollment during each of the four quarters. This downward trend is consistent with an overall decline in enrollment in the Florida Medicaid program during that time period.

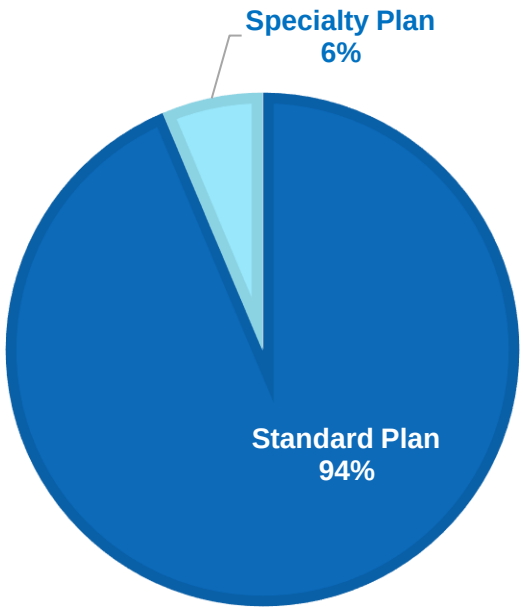


The following graph demonstrates enrollment in the MMA program since the program rolled out statewide.



Individuals eligible for the MMA program who have certain special conditions may enroll into one of the MMA specialty plans, if a plan is available in their region that focuses on their condition. Specialty plans are designed for target populations; for example, children with chronic conditions or recipients who have been diagnosed with HIV/AIDS. Specialty health plan provider networks incorporate specialized clinical programs and/or providers with expertise to serve their target population. As the graph below illustrates, specialty plan enrollment represents 6% of the total MMA program population.

DY13
MMA Specialty Plan Enrollment



Enrollment Statistics:

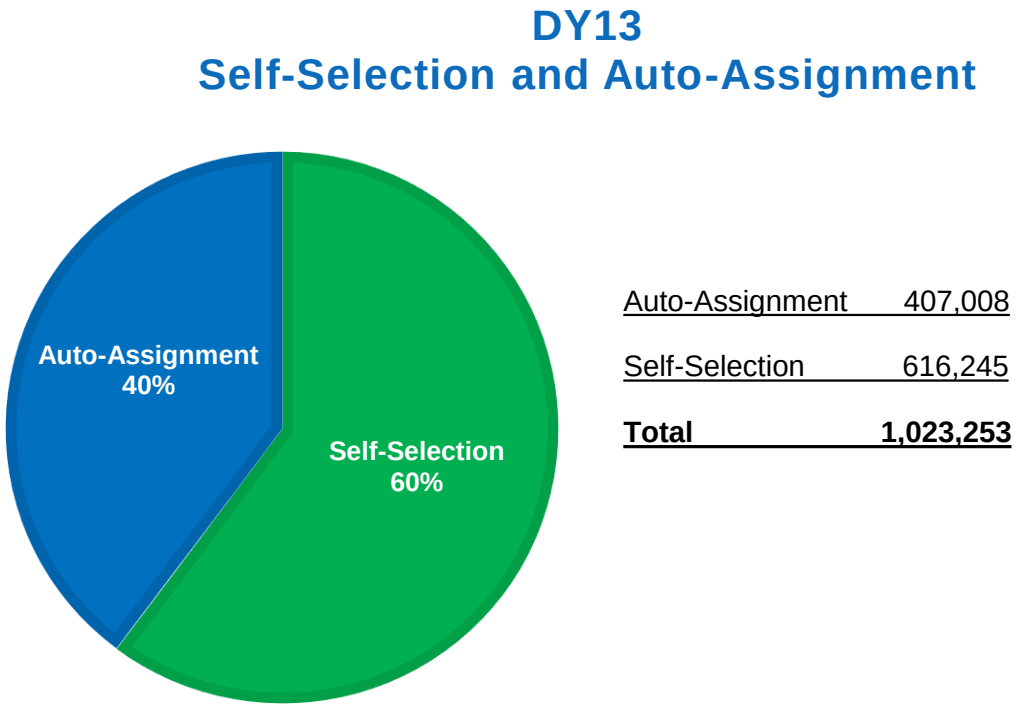
Specialty Plan	237,637
Standard Plan	3,498,398
Total	3,769,035

The complete MMA Enrollment Report is contained in **Attachment II.**

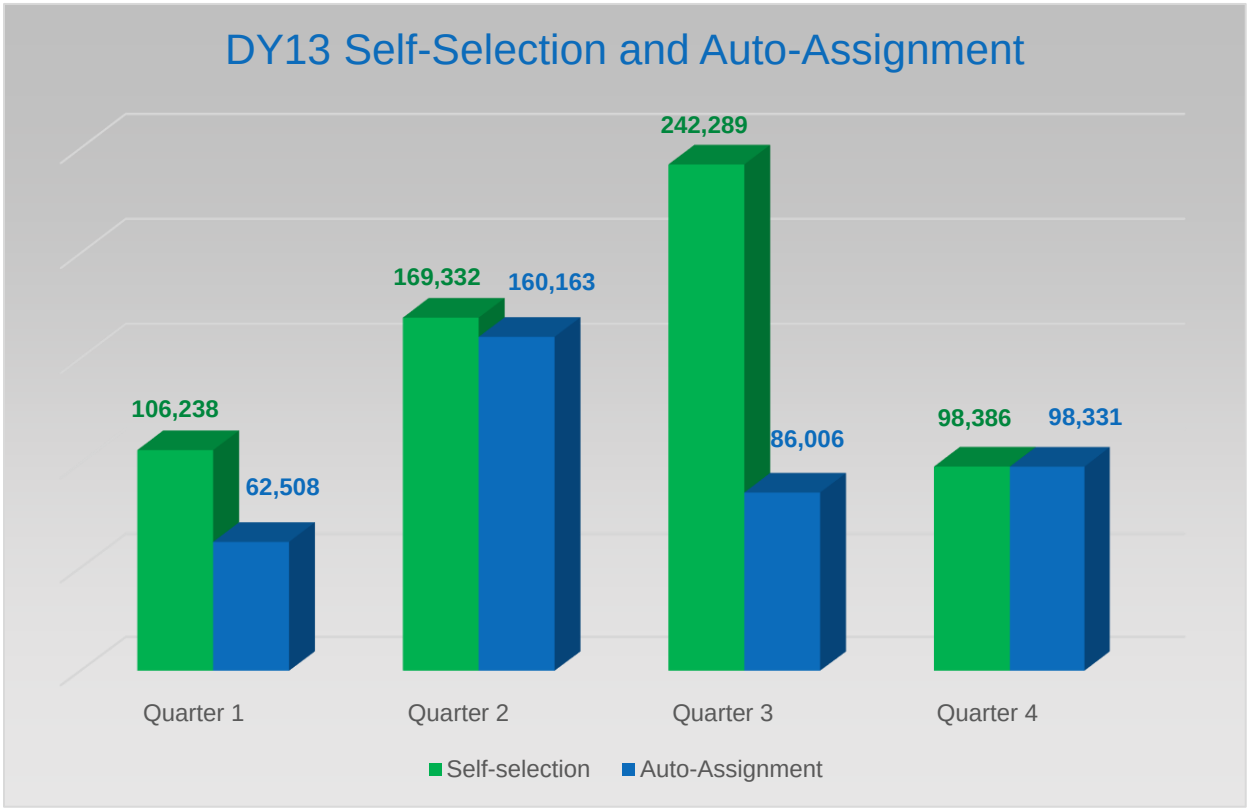
Self-Selection and Auto-Assignment

Florida encourages individuals to take an active role in the MMA plan selection process prior to or upon their eligibility determination. Information regarding the MMA plan enrollment process, as well as plan availability in their area, is provided upon submission of their Florida Medicaid eligibility application. If the individual does not select an MMA plan prior to becoming Medicaid eligible, the State utilizes an algorithm to select an MMA plan that best fits their needs, and immediately enrolls them into that plan. This enrollment process ensures that there is no lag time in between the eligibility determination and MMA plan enrollment, which grants recipients immediate access to care. Individuals have 120 days after Medicaid enrollment to change managed care plans.

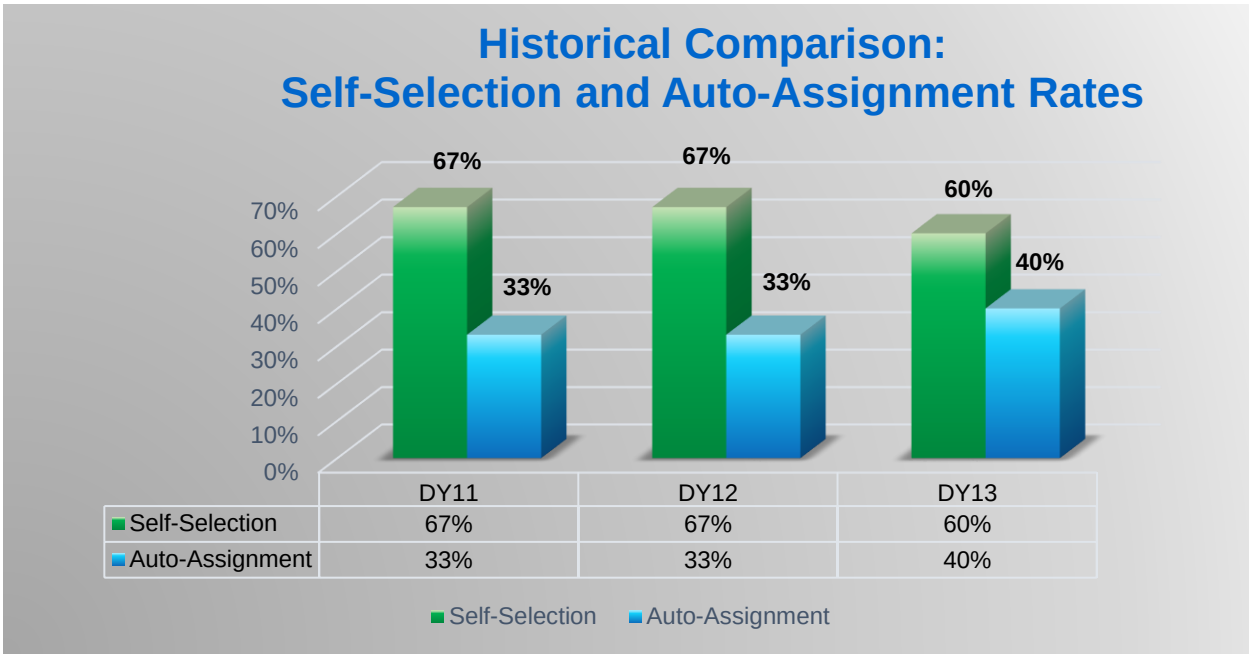
The State's efforts to engage individuals by encouraging them to take an active role in their health care by selecting an MMA plan prior to their eligibility determination, or during the 120-day post enrollment change period, have been successful, as 60% of individuals in DY13 actively chose their MMA plan.



In DY13, self-selections outnumbered auto-assignments in all four quarters:



The self-selection rate has remained consistent throughout the MMA program's statewide status, with 60-67% of participants self-selecting and 33-40% being auto-assigned.



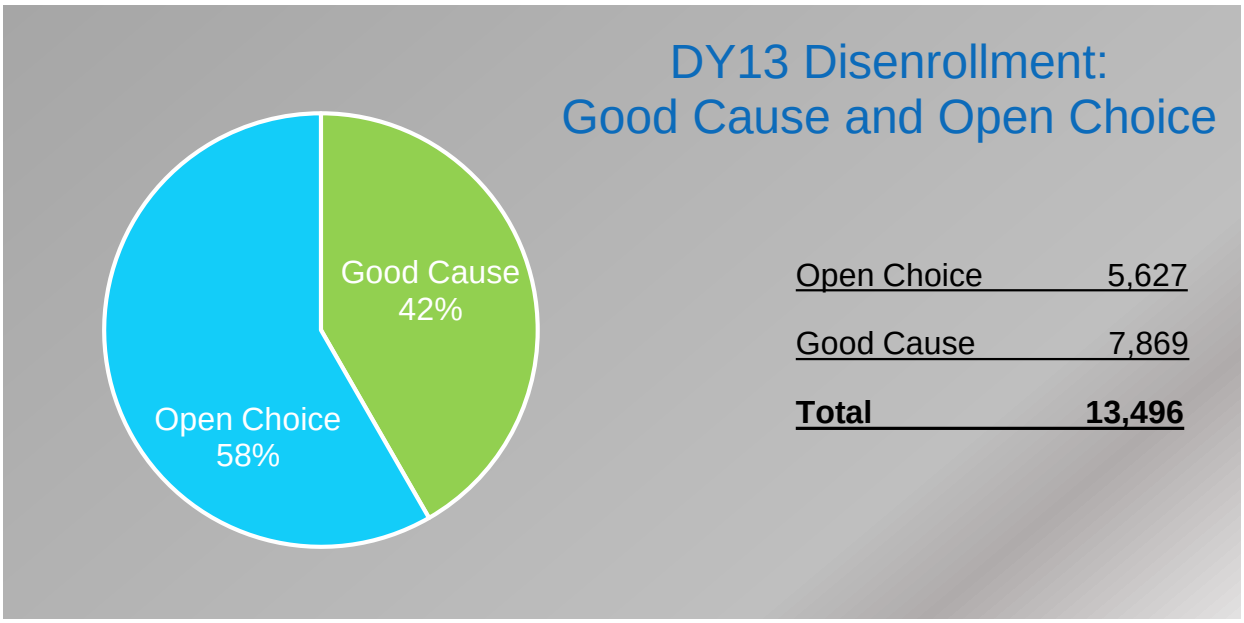
As shown in the chart above, there was a 7-percentage point decrease in self-selections from DY12 to DY13. This is due to the MMA plan re-procurement process; individuals whose MMA plans were no longer going to be contracted with the State or no longer serve in the individual's region received an auto-assignment followed by an open choice period.

Managed Medical Assistance Disenrollment

The State differentiates disenrollment from MMA plans into two ways:

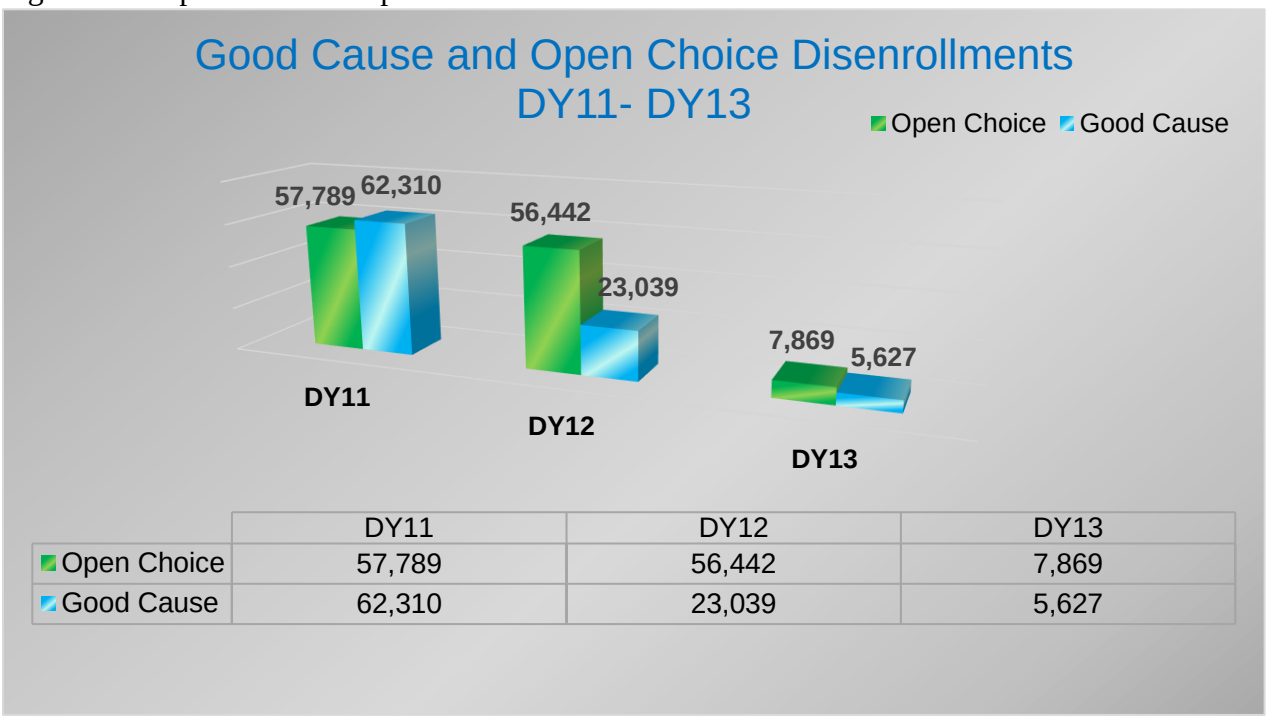
1. Good Cause Disenrollment
2. Open Choice Period Disenrollment

Good cause disenrollment occurs when an enrollee disenrolls from their MMA plan either outside of the 120-day post enrollment period or outside of their open enrollment period. Beyond the initial 120-days, and outside of the annual open enrollment period, disenrollment from an MMA plan is only permitted when there is good cause; good cause is defined in the Code of Federal Regulations. Open choice disenrollments are disenrollments that occur during the initial 120-day open choice period and/or during the annual open enrollment period, when recipients are permitted to change their MMA plans without cause. During DY13, the open choice disenrollment rate was higher than that of the good cause disenrollment rate.



Consistent with DY12, the DY13 disenrollment rate for open choice was greater than the good cause disenrollment rate. However, in DY13, open choice disenrollments accounted for approximately 58% of MMA plan disenrollment; this percentage is down from DY12 when the open choice disenrollment figure was 71%.

As illustrated below, good cause disenrollment has significantly decreased from DY11 to DY13, as has open choice disenrollment, which, in the same timeframe, has declined by approximately 90%. The significant decrease in disenrollment figures is attributable to the SMMC re-procurement process, which permitted all active enrollees to make MMA plan choices without regard to an open enrollment period.



	DY11	DY12	DY13
Open Choice	57,789	56,442	7,869
Good Cause	62,310	23,039	5,627

Dual Integration for Medicare Recipients

Individuals fully eligible for both Medicare and Florida Medicaid (dually eligible recipients) are required to enroll in an MMA plan to receive Florida Medicaid services. Dually eligible recipients who do not choose an MMA plan are auto-assigned to a plan using the dual integration auto-assignment algorithm. The algorithm promotes provider and service alignment between Medicare and Medicaid by enrolling dually eligible recipients who are enrolled in a Medicare Advantage plan into the MMA plan considered to be a "sister plan" to their Medicare Advantage plan.

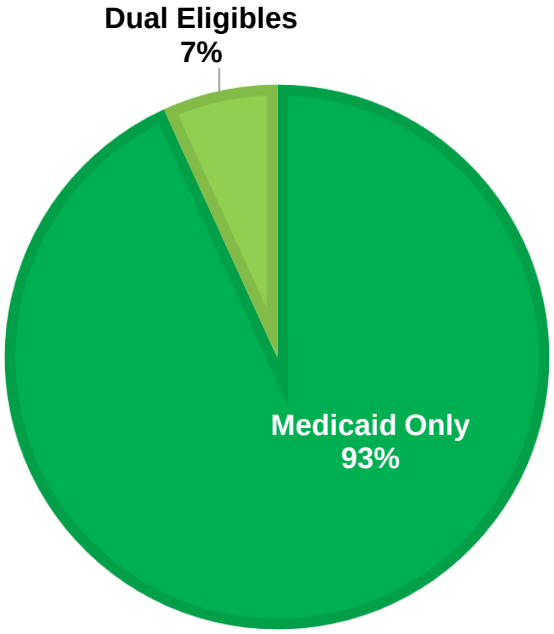
Dual integration enrollments occur primarily during the third quarter, which is the Medicare open enrollment period. The total number of new dually eligible recipients enrolled into sister MMA plans during each quarter of DY12 and DY13 followed the projected trend.

The total number of dually eligible recipients enrolled in MMA plans during DY13 was 254,758, which represented 7% of the total MMA program enrollment.

Dual Eligiblity Enrollment DY13

Eligibility Statistics:

Medicaid Only	3,481,277
Dual Eligibles	254,758
Total	3,769,035

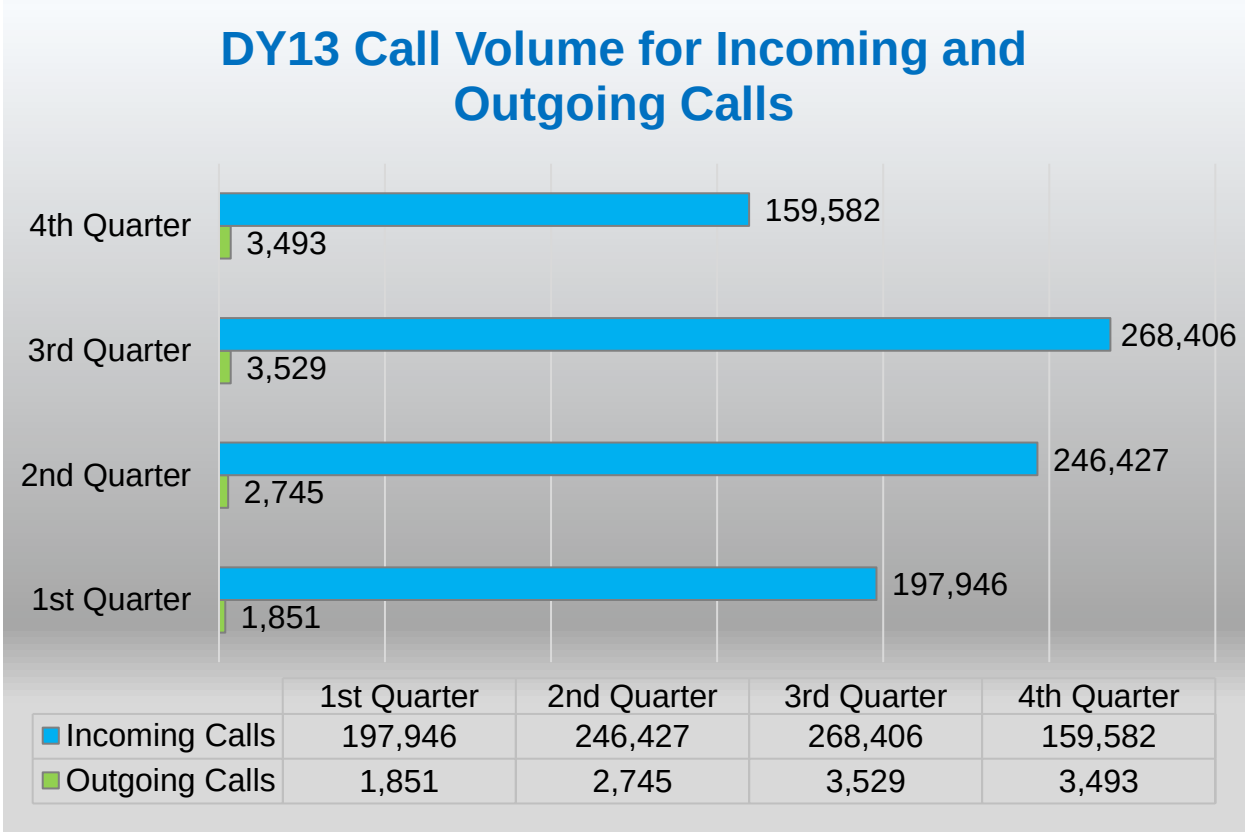


Choice Counseling Activities

The Agency contracts with an enrollment broker/choice counseling vendor to manage Florida Medicaid recipients' enrollment in, and disenrollment from, managed care plans. This includes the operation of the call center and other outreach activities, such as mailings.

Choice Counseling Call Center

Incoming calls represented 99% of the call center volume during DY13. As shown below, incoming calls significantly increased during the second and third quarters of DY13; this is due to the SMMC re-procurement enrollment activities.

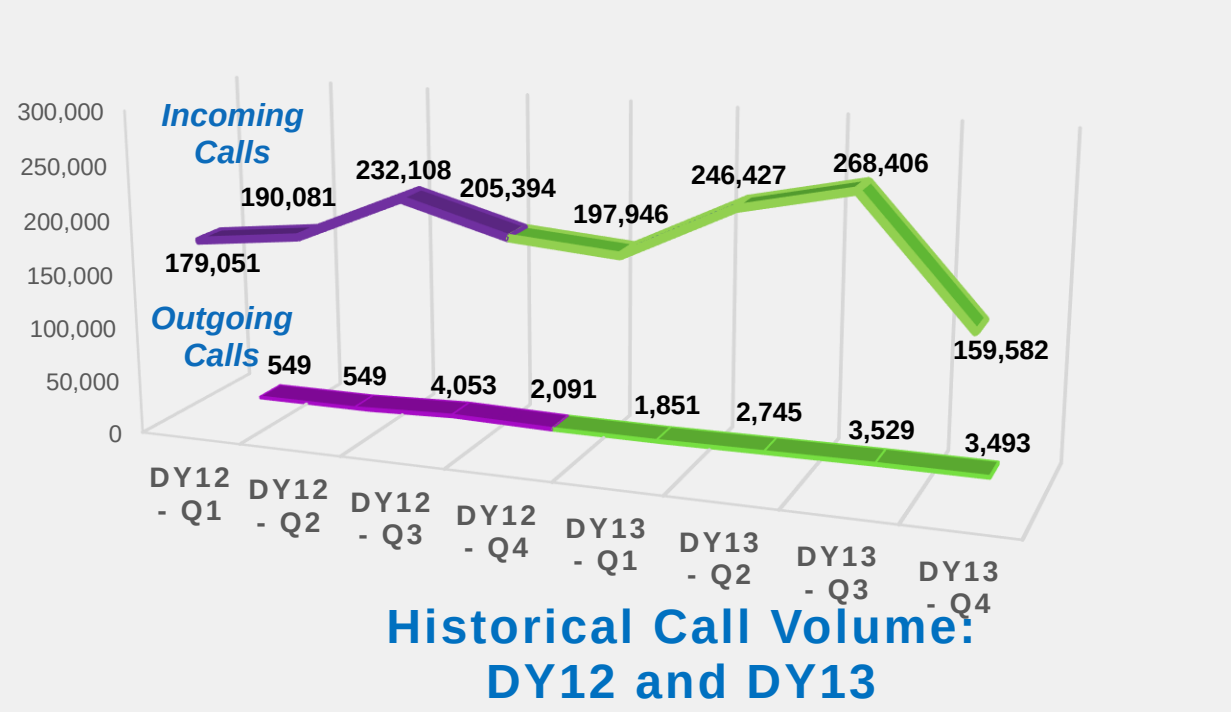


	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Incoming Calls	197,946	246,427	268,406	159,582
Outgoing Calls	1,851	2,745	3,529	3,493

During the past two demonstration years, there has been an increase in the incoming call volume during the second and third quarters, along with an increase in outgoing calls during the third and fourth quarters. This however does not indicate a trend, as there were unique activities that occurred during the same timeframes in the past two demonstration years.

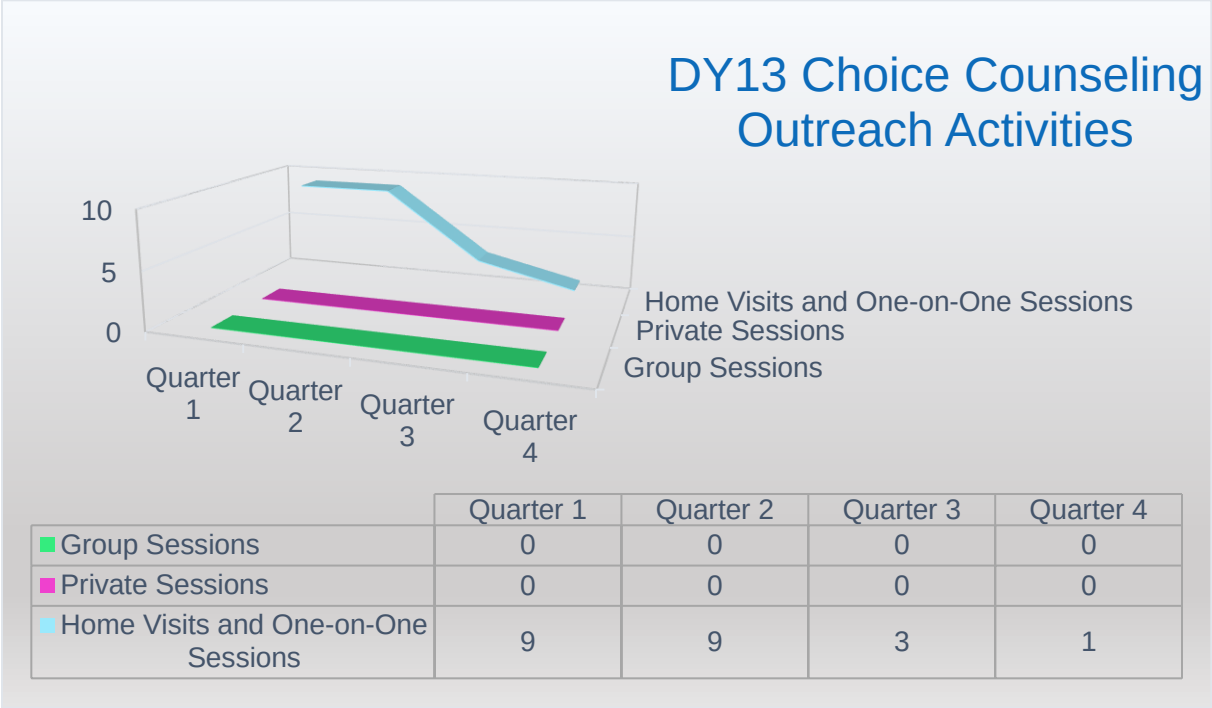
In DY12, the call volume increases were due to consolidation of the 1915(c) Project AIDS Care Waiver, Adults with Cystic Fibrosis Waiver, and Traumatic Brain and Spinal Cord Injury Waiver into the SMMC program. During the second and third quarters, a large percentage of MMA recipients were permitted to change their MMA plans during open enrollment. This resulted in the higher incoming call volume initially and the higher outgoing call volume subsequently.

Similarly, in DY13 the Agency was facilitating the re-procurement process, which involved MMA recipients selecting new MMA health plans. In both years, the Agency disseminated information and correspondence, during the second and third quarters, instructing MMA recipients to select a new MMA health plan. This is what led to the increased call volume, both incoming and outgoing in DY12 as well as DY13.



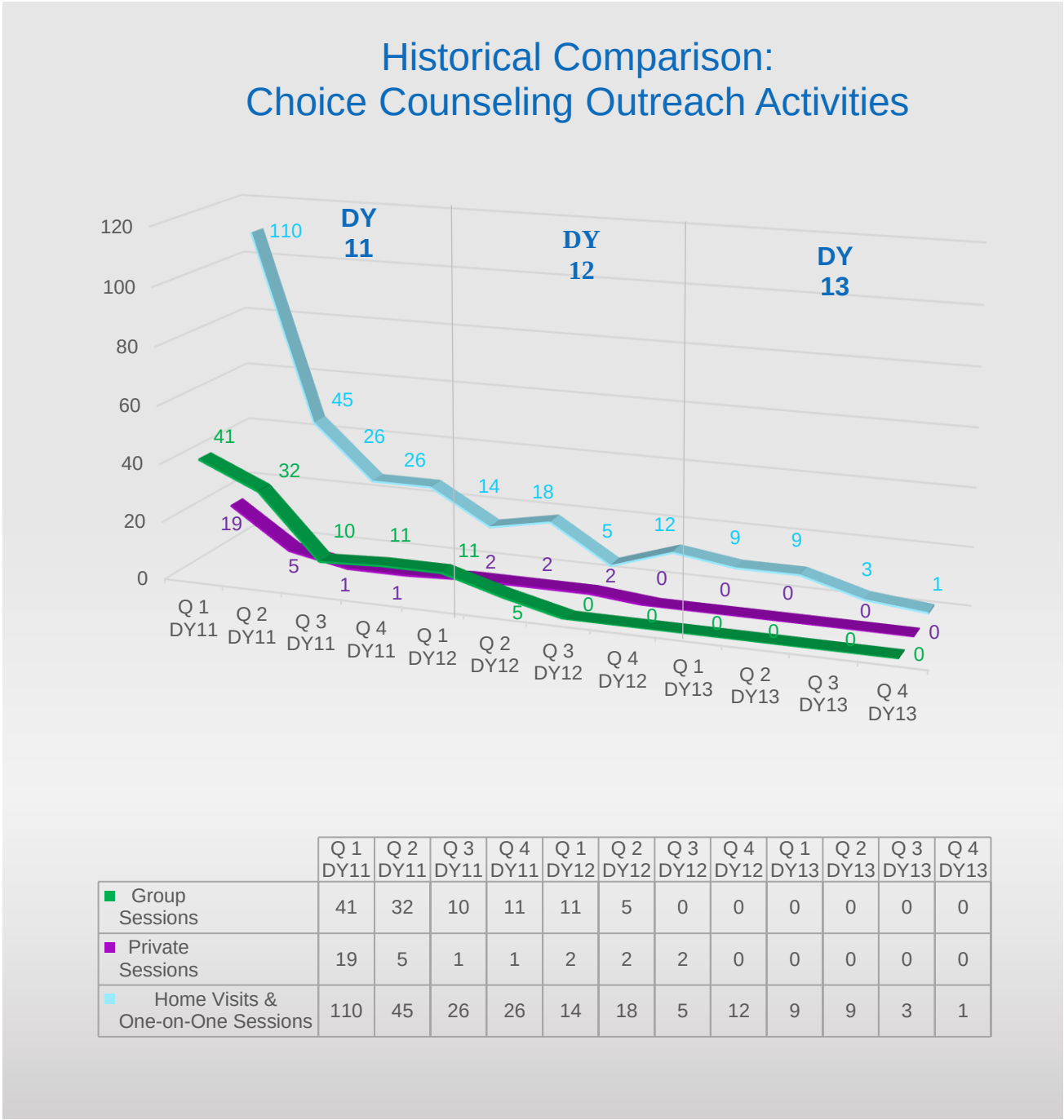
Choice Counseling Outreach Activities

Choice counseling outreach activities include group counseling sessions, private counseling sessions, and home visits, which also entail one-on-one counseling sessions. As illustrated below, the overall demand for home visits and one-on-one choice counseling sessions continues to decrease; the maximum demand in DY13 was 50% lower than DY12.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Group Sessions	0	0	0	0
Private Sessions	0	0	0	0
Home Visits and One-on-One Sessions	9	9	3	1

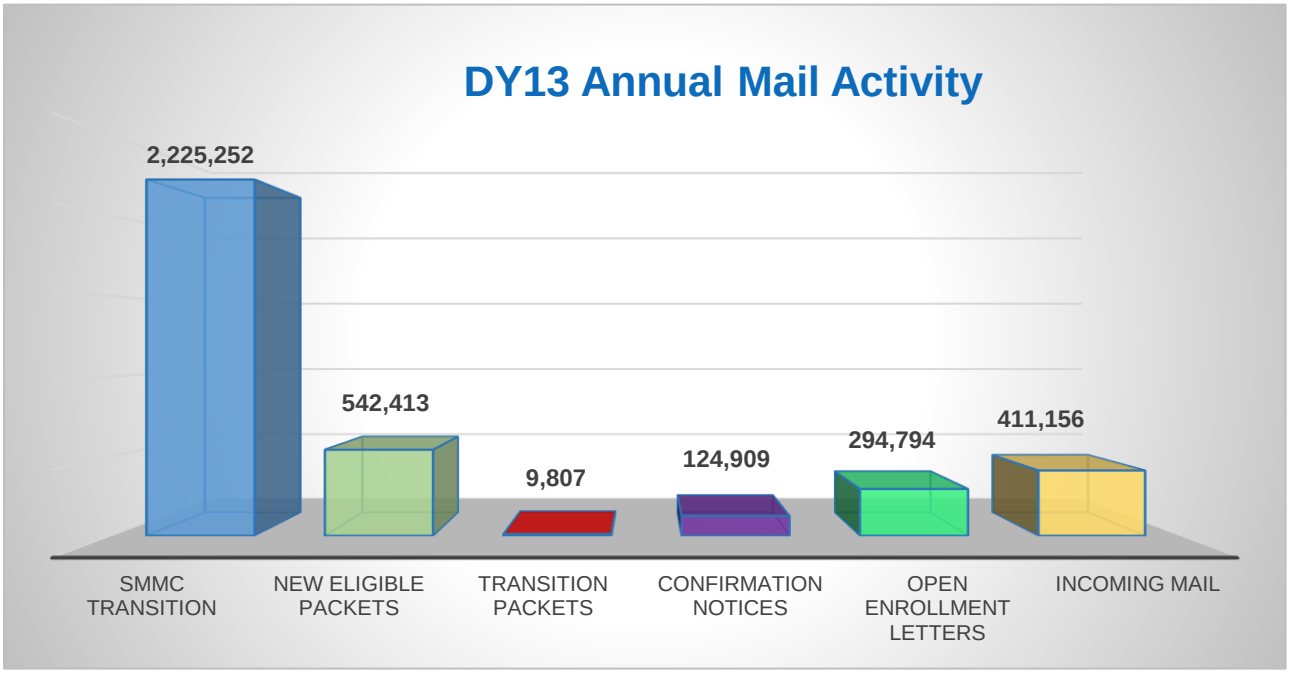
The downward trend of recipients selecting these choice counseling outreach methods experienced from DY12 to DY13 is a continuation of a larger trend. In the chart below, the downward trend is evident over the course of the past three demonstration years. This downward shift is due to recipients opting to access choice counseling services through the online portal or the call center. This is not surprising as the MMA program matures, and recipients become more comfortable and familiar with the program.



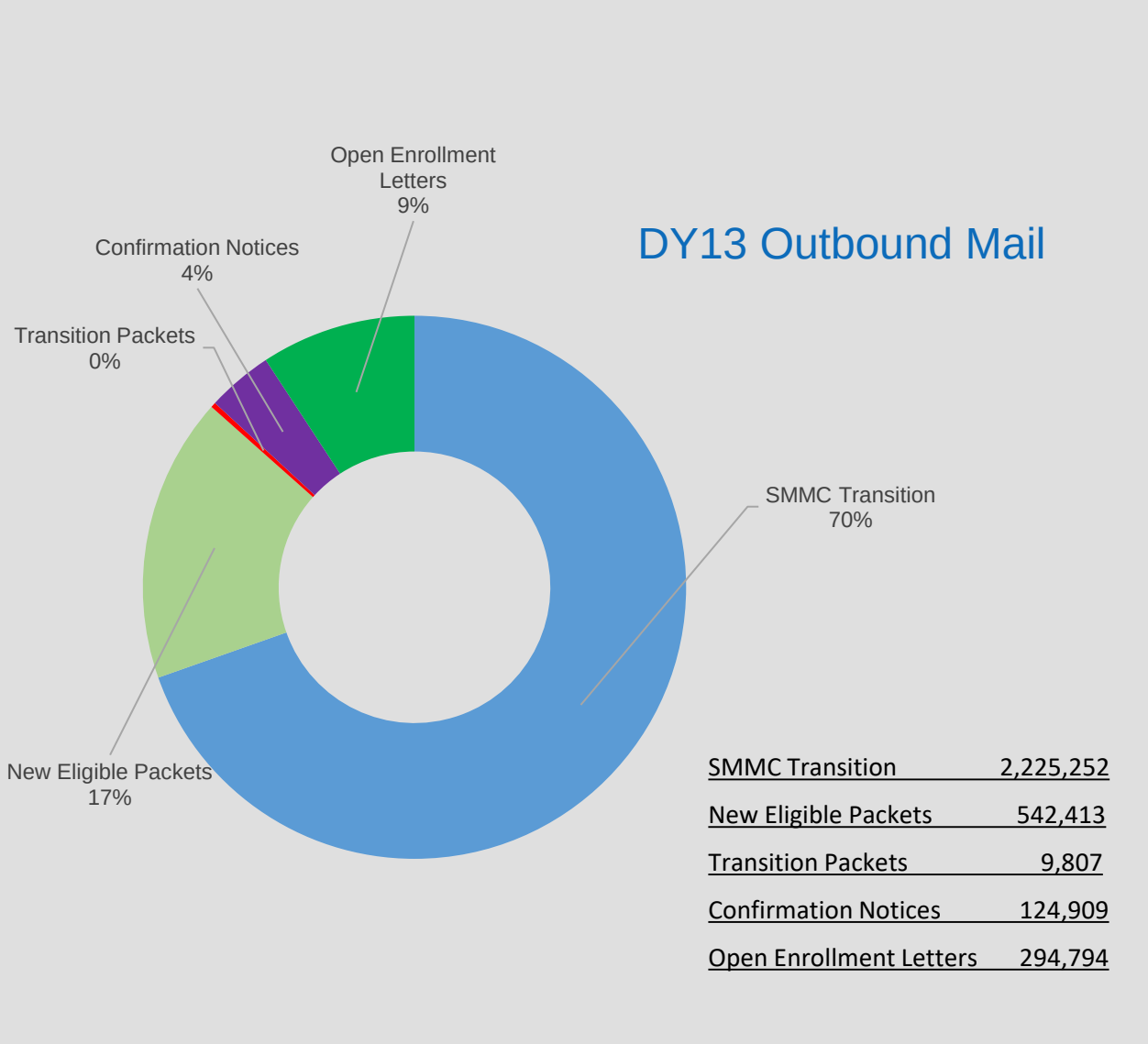
	Q 1 DY11	Q 2 DY11	Q 3 DY11	Q 4 DY11	Q 1 DY12	Q 2 DY12	Q 3 DY12	Q 4 DY12	Q 1 DY13	Q 2 DY13	Q 3 DY13	Q 4 DY13
Group Sessions	41	32	10	11	11	5	0	0	0	0	0	0
Private Sessions	19	5	1	1	2	2	2	0	0	0	0	0
Home Visits & One-on-One Sessions	110	45	26	26	14	18	5	12	9	9	3	1

Choice Counseling Mail Activities

In addition to the other choice counseling activities listed previously, the State's choice counseling vendor conducts the mailing of the following items to MMA participants: SMMC transition letters, new eligible packets, transition packets, confirmation notices, and open enrollment letters. They are also responsible for processing incoming mail received from MMA participants.



During DY13, the State's choice counseling vendor mailed out 2,225,252 SMMC transition letters due to the re-procurement process, which accounted for 70% of the total outgoing mail, as detailed in the next chart.



Demonstration Programs

Healthy Behaviors:

In an effort to encourage Medicaid recipients to adopt lifestyles and make other behavioral changes that lead to improved health, Florida implemented Healthy Behaviors Programs. These programs encourage and incentivize healthy behaviors by offering structured interventions with rewards for recipients who participate in or complete the program.

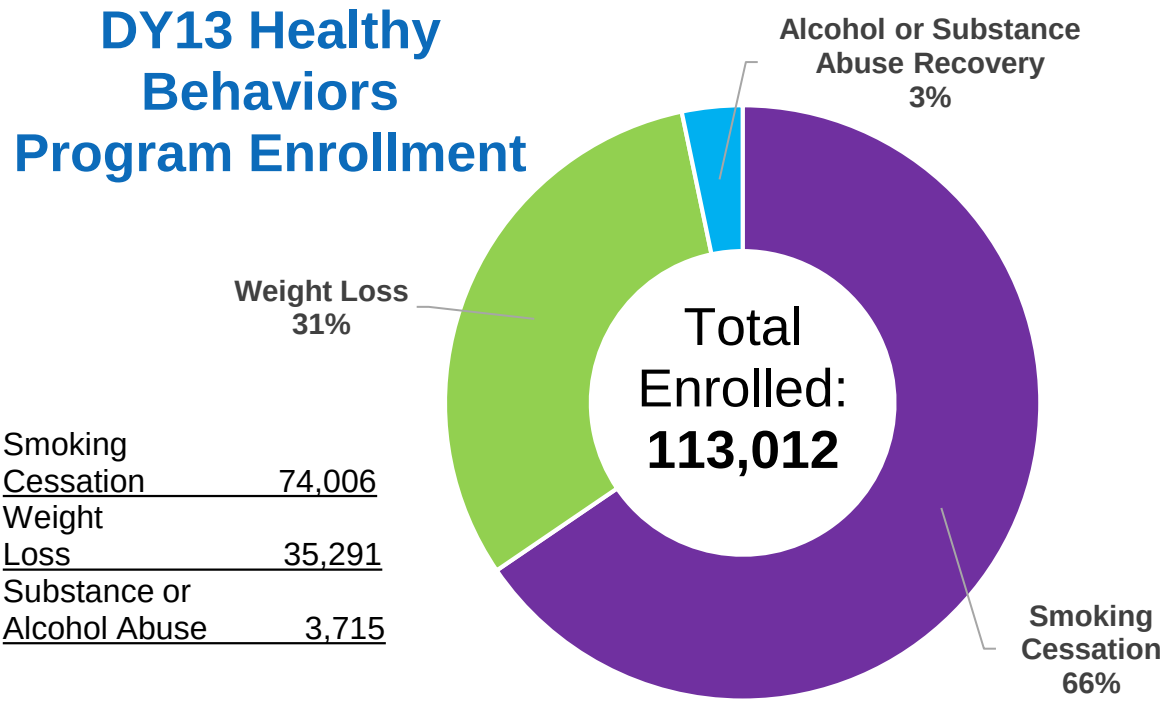
The MMA plans are required to offer the three following healthy behaviors programs:

- Medically Approved Smoking Cessation Program
- Medically Directed Weight Loss Program
- Alcohol or Substance Abuse Treatment Program

However, in addition to the required programs, the Agency encourages health plans to offer other healthy behaviors programs. Several plans offer programs in dental, well child visits, and prenatal care, all of which are in line with the State's goals and areas of interest for the MMA program.

The itemized data for the DY13 healthy behaviors programs is in **Attachment III**; some of the MMA plans only reported data for quarters one and two or quarters three and four. This is due to the overlap in reporting from the previous MMA plan contracts and the current MMA plan contracts; Attachment III details data from both contracts.

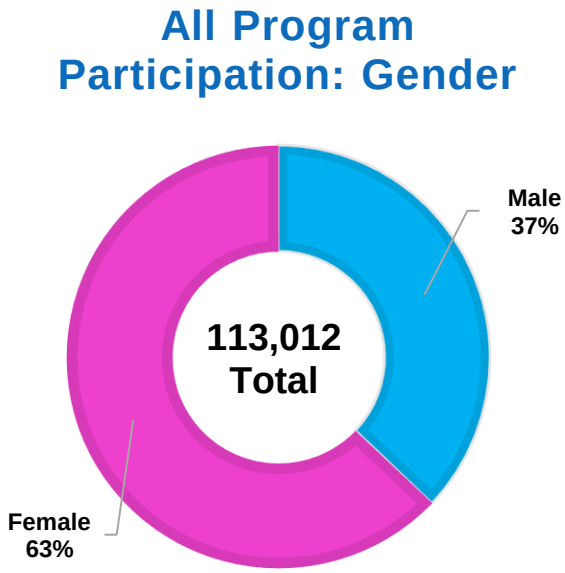
All of the healthy behaviors programs are voluntary for recipients and require written consent from each participant prior to enrollment into the program. The following charts provide participation data for the required programs in DY13.

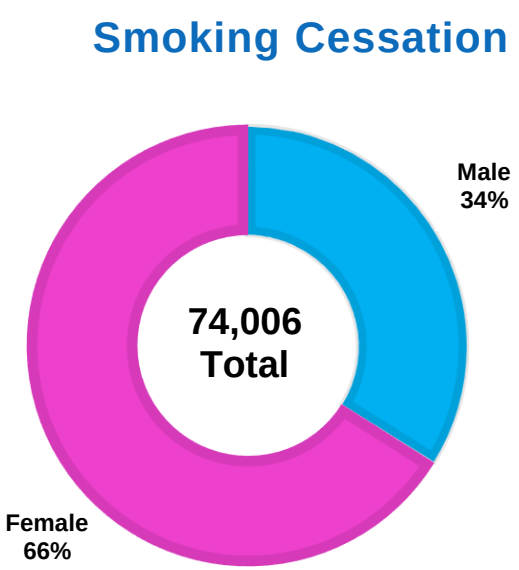


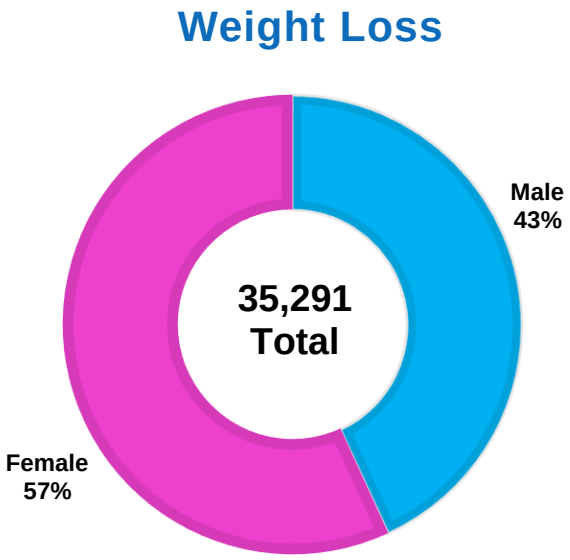
In past demonstration years, the Healthy Behaviors Medically Directed Weight Loss Program has always been the highest performing program. However, as shown in the graph above, the Medically Approved Smoking Cessation Program's enrollment was 35 percentage points higher than the Medically Directed Weight Loss Program in DY13.

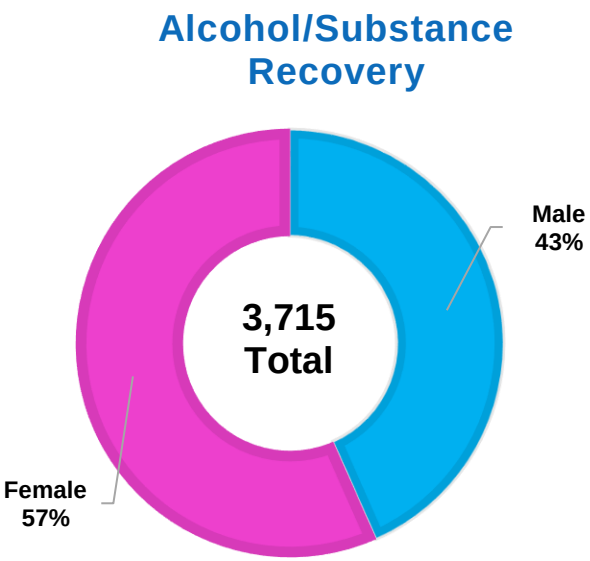
Healthy Behavior Program Participation by Gender

The gender enrollment demographic breakdown, within the healthy behaviors programs, remained consistent with that of past demonstration years. Thus far, females have had a higher enrollment rate than that of males, overall and within each of the healthy behaviors programs, which remains true in DY13 as illustrated below.



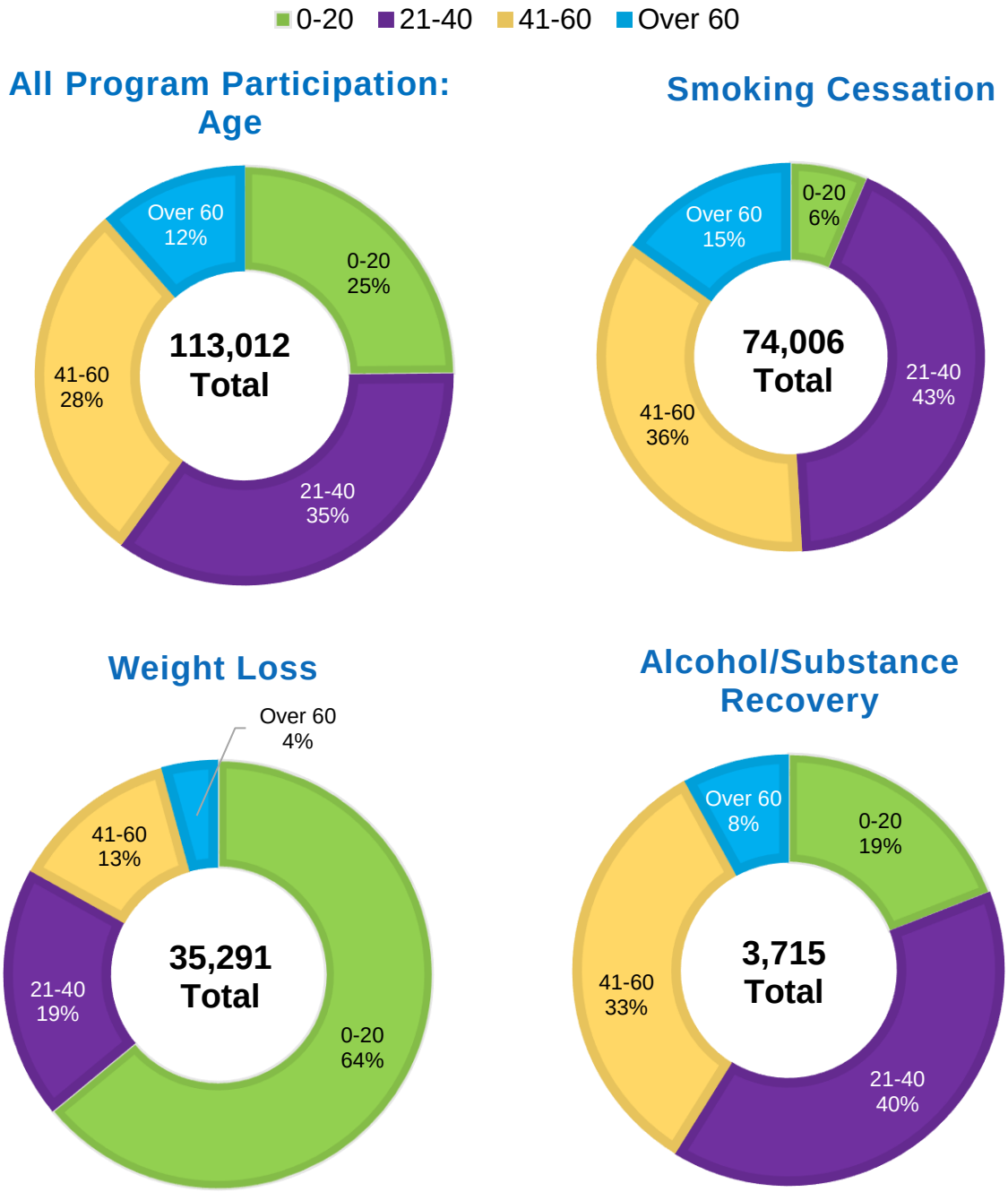


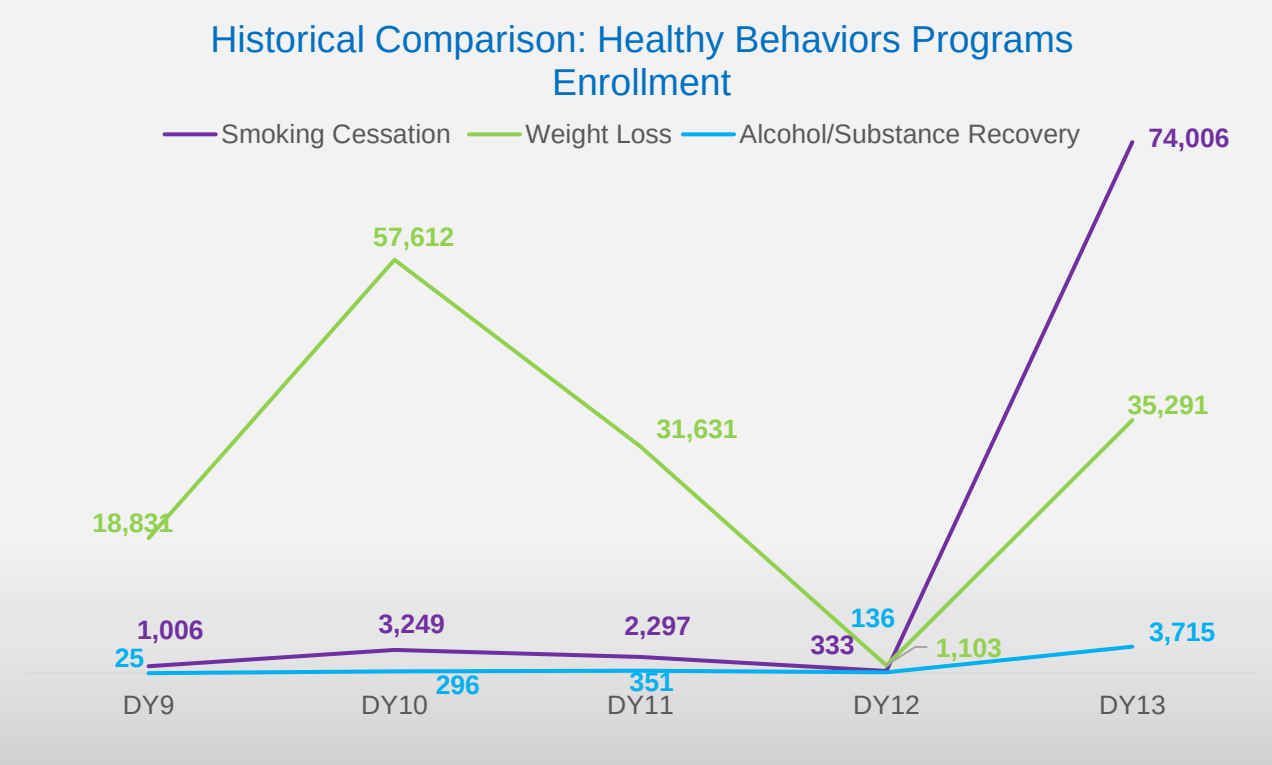




Healthy Behavior Program Participation by Age

In the past, the age demographic group with the highest enrollment in the healthy behaviors programs has varied between the 0-20 and 21-40 age groups. In the past two demonstration years, DY12 and DY11, the 0-20 age demographic has had the highest enrollment rate, and in DY9 the 41-60 age group had the highest enrollment rate; however, they only outperformed the 0-20 age group by two participants. Thus, DY13 is the first year the 41-60 age bracket has significantly, by 7 percentage points, outnumbered the 0-20 age demographic.





The healthy behaviors program enrollment increased drastically from DY12 to DY13, across all three of the required healthy behavior programs. The DY13 enrollment spike accounts for the largest enrollment increase in healthy behaviors programs enrollment since the program's inception.

Healthy Behavior Program Participation and Completion

DY13 Healthy Behaviors Program Enrollment and Completion

Healthy Behaviors Programs	Program Enrollment	Program Completion	Percentage Completed
Medically Approved Smoking Cessation	74,006	102	.14%
Medically Directed Weight Loss	35,291	115	.33%
Medically Approved Alcohol or Substance Abuse Recovery	3,715	25	.67%
Healthy Behaviors Program Total	**113,012**	**242**	**.21%**

Low Income Pool (LIP)

Program Description

On October 19, 2005, CMS approved Florida's 1115 Research and Demonstration Waiver relating to Medicaid reform. In the original waiver, the Low Income Pool (LIP) program was established to ensure continued support for the provision of health care services to Medicaid recipients, the under insured, and uninsured populations. The program has evolved over the years of the waiver and is now a charity care pool that can be used to compensate hospitals, medical school faculty practice plans, federally qualified health centers, rural health clinics, and community behavioral health providers for their uncompensated charity care.

Demonstration Year 13 Update

During DY13, the Agency submitted the following Final Reports to CMS:

- SFY 2019-20 Projected LIP Distribution
- SFY 2017-18 LIP Payments and FY 2017 Charity Care Report
- SFY 2017-18 Final Intergovernmental Transfer Report
- SFY 2016-17 LIP Cost Limit Report

Process and Findings

LIP funding supports providers that furnish uncompensated charity care to low-income individuals who are uninsured. Hospitals, federally qualified health centers (FQHCs), rural health clinics (RHCs), medical school faculty physicians, and community behavioral health providers are eligible to receive LIP funds. In order to receive LIP funds, providers must meet the participation requirements in STC #71.

The LIP Program pays providers based on their charity care cost. First, hospitals are ranked from high to low based on their percentage of charity care costs to commercial costs as well as statutory designations and ownership status. Then, providers are divided into tiers based on their level of charity care cost to commercial costs, and are paid a prescribed percentage of their charity care cost. Providers may be paid up to 100% of their charity care costs.

The funding for the LIP program is contingent upon the availability of local government funds called intergovernmental transfers (IGTs) that must be contributed, as state match, to pull down federal matching funds. The state matching percentage is based on the Federal Medical Assistance Program (FMAP).

IGT providers must sign a letter of agreement (LOA) with the Agency. The LOAs specify the amounts that the Agency can collect from each governmental entity, which then submit these funds via IGTs to the Agency. The Agency uses those funds for drawing down the federal matching share of LIP funds.

In DY13, there were 44 IGT providers that contributed IGTs in the amount of $363,342,087.

The total LIP allotment for each demonstration year (DY12 through DY16) is capped at $1,508,385,773. In DY13, $857,693,316 was paid out to eligible providers.

Behavior Health and Supportive Housing Assistance Program

Housing Waiver Overview

In March 2019, the Agency received approval for an 1115 waiver amendment to implement a pilot program in Medicaid Regions 5 and 7 that will provide housing support services to recipients who have a severe mental illness (SMI), substance use disorder (SUD), a combination of SUD and SMI, and are homeless or at risk of being homeless.

- Region 5 consists of Pasco and Pinellas counties (St. Petersburg, Clearwater)
- Region 7 consists of Seminole, Brevard, Orange, and Osceola counties (Orlando, Kissimmee, Titusville)

These housing support services will be available only to enrollees in MMA plans that apply, and are selected, to participate in the pilot program.

Services Provided Under the Behavior Health and Supportive Housing Assistance Program

MMA plans that participate in the housing program will be able to provide the following services to members who qualify for the pilot:

- **Transitional Housing Services:** Services that support a member in the preparation for and transition into housing. This includes but is not limited to:
  - Conducting tenant screenings and housing assessments
  - Developing individualized housing support plans
  - Assisting with housing searches and the application process
  - Identifying resources to pay for on-going housing expenses such as rent
  - Ensuring that living environments are safe and ready for move-in
- **Tenancy Sustaining Services:** Services that support a member in being a successful tenant.
  - Early identification and interventions for behaviors that may jeopardize housing such as late rental payment or other lease violations
  - Education and training on the roles, rights and responsibilities of the tenant and landlord
  - Coaching on developing and maintaining key relationships with landlord/property managers
  - Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction, advocacy and linkage with community resources to prevent eviction,
  - Assistance with the housing recertification process
  - Coordinating with enrollees to review, update, and modify their housing support and crisis plans
- **Mobile Crisis Management:** The delivery of immediate de-escalation services for emotional symptoms, and/or behaviors at the location in which the crisis occurs. Provided by a team of behavioral health professionals who are available 24/7 for the purpose of preventing loss of a housing arrangement or emergency inpatient psychiatric service when possible.

- **Self-Help/Peer Support:** Person-centered service promoting skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills with the assistance of a peer support specialist.

DY13 Activities: Behavior Health and Supportive Housing Assistance Program

- Received waiver amendment approval from CMS in March 2019.
- Notified the health plans as well as the public of the upcoming opportunity.
- Facilitated communication with stakeholders about the upcoming opportunity.
- Developed the program application.
- Began planning and the development of the reporting mechanism for the plans.
- Initiated the rate setting process for the health plans.

Housing Waiver Moving Forward

- Applications were sent to the health plans.
  - Five health plans submitted applications, and four were selected to participate in the pilot.
- The health plan preparation timeline is from program notification until program implementation.
- Implementation of the Behavioral Health and Supportive Housing Assistance program, including the availability of services, is expected in October 2019.

Section II: Performance Metrics

Quality Assurance and Monitoring Activities

Florida vs National Averages for Healthcare Effectiveness Data Information Set (HEDIS)

HEDIS is a set of performance measures for medical managed care, designed to allow customers to compare health plan performance, both regionally and nationally. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA). The Agency compares the HEDIS National Medicaid Means and Percentiles to the performance measures submitted from Florida's MMA plans.

The State has continued to see a significant improvement in its Medicaid quality scores since the inception of the MMA program. The percentage of calendar year 2017 HEDIS scores at or above the national average increased by 10 percentage points over calendar year 2016.

Calendar year 2018 was a transition year from the previous contracts to the new contracts. Data from 2018 is being reviewed and will be released later in Fall 2019.

- The Agency posts detailed MMA Plan scores on its website: http://ahca.myflorida.com/Medicaid/quality_mc/index.shtml.

Additionally, the Agency, to promote transparency, publishes a Medicaid Health Plan Report Card, which highlights key performance measures in a consumer-friendly format. The Report Card is updated annually and uses a five-star rating system, grouping HEDIS measures into related and understandable categories, such as Keeping Kids Healthy and Pregnancy-Related Care.

- The Health Plan Report Cards are available online at the Agency's award-winning Consumer Health Care Transparency website, www.FloridaHealthFinder.gov. A Report Card example is included on the following page:

Quality of Care Indicators - Ratings

All Florida Counties
Plan Type: Medicaid Health Plans
Data are for services received in 2017

◉ **Medicaid Health Plan Report Card**

To view individual measures in a category, click one of the following:

- ○ **Pregnancy-related Care**
- ○ **Keeping Kids Healthy**
- ○ **Children's Dental Care**
- ○ **Keeping Adults Healthy**
- ○ **Living with Illness**
- ○ **Behavioral Health Care**

Directions:

View the results below or click a column heading to sort by that column.

Statewide Information for Plans Currently Operating in Florida Counties

Plan Name	Pregnancy-related Care	Keeping Kids Healthy	Children's Dental Care	Keeping Adults Healthy	Living with Illness	Behavioral Health Care
Aetna Better Health of Florida	★★★★★	★★★★☆	★★★☆☆	★★★★☆	★★★★★	★★★★☆
Children's Medical Services *	★☆☆☆☆	★★★★☆	★★★★☆	N/A	★☆☆☆☆	★★★☆☆
Clear Health Alliance *	★★★☆☆	N/A	★★☆☆☆	★★★★☆	★★★☆☆	N/A
Community Care Plan	★★★★★	★★★★☆	★★★★☆	★★★★☆	★★★★★	★★★★☆
Florida Community Care ‡	N/R	N/R	N/R	N/R	N/R	N/R
Florida MHS (Magellan) *	★☆☆☆☆	★☆☆☆☆	★★☆☆☆	★★☆☆☆	★★☆☆☆	★★★☆☆
Humana Medical Plan, Inc.	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★★☆	★★★☆☆
Lighthouse Health Plan, LLC ‡	N/R	N/R	N/R	N/R	N/R	N/R
Miami Children's Health Plan, LLC ‡	N/R	N/R	N/R	N/R	N/R	N/R
Molina Healthcare of Florida, Inc.	★★★★★	★★★☆☆	★★★☆☆	★★★★☆	★★★★☆	★★★★☆
Prestige Health Choice	★★★☆☆	★★★☆☆	★★★★☆	★★★★☆	★★☆☆☆	★★★★★
Simply Healthcare Plans, Inc.	★★★★★	★★★★☆	★★★★☆	★★★★★	★★★★☆	★★★★☆
Staywell Health Plan	★★★★☆	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★★★★☆
Staywell Health Plan of Florida - SMI * ‡	N/R	N/R	N/R	N/R	N/R	N/R
Sunshine Health Child Welfare Specialty Plan *	★☆☆☆☆	★★★★☆	★★★★★	N/A	N/A	★★★☆☆
Sunshine State Health Plan, Inc.	★★★☆☆	★★★☆☆	★★★☆☆	★★★★☆	★★★☆☆	★★★★☆
United Healthcare of Florida, Inc.	★★★★☆	★★★★☆	★★★☆☆	★★★★☆	★★★★☆	★★★★☆
Vivida Health ‡	N/R	N/R	N/R	N/R	N/R	N/R

Ratings Key:

★★★★★	**Best**	at or above 50% of all Medicaid health plans' scores
★★★★☆	**Good**	better than at least 40% of all Medicaid health plans' scores
★★★☆☆	**Fair**	better than at least 25% of all Medicaid health plans' scores
★★☆☆☆	**Poor**	better than at least 10% of all Medicaid health plans' scores
★☆☆☆☆	**Very Poor**	worse than 90% of all Medicaid health plans' scores
N/A		Not Measurable/Small Population
N/R		Not Rated

Consumer Assessment of Healthcare Providers (CAHPS)

The Consumer Assessment of Healthcare Providers Survey (CAHPS) is a program under the Agency for Healthcare Research and Quality, which consists of a series of patient surveys rating health care experiences. The CAHPS Statewide Survey averages, for both the adult and child surveys as well as the plan-specific rates for the reporting period, will be available at: www.FloridaHealthFinder.gov

The CAHPS Survey period for 2019 included the State's MMA re-procurement and health plan transition period. This is important to note as the survey only includes individuals who were enrolled in the same MMA Health Plan for at least six months. Results remained consistently high, as they have been in previous years. The following tables contain a few highlights from the survey results for 2019 along with the 2016-2018 results for comparison.

Adult Survey Results

CAHPS Item	Rate Description	2016	2017	2018	2019*
Rating of Health Plan	% of Respondents rating their Health Plan an 8, 9, or 10 on a scale of 0-10	73%	76%	76%	77%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	80%	83%	81%	82%
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	82%	84%	82%	83%
Customer Service	% of respondents reporting they usually or always get the help/info needed from their plan's customer service	88%	88%	88%	88%
Rating of Health Care	% of respondents rating their health care an 8, 9, or 10 on a scale of 0-10	75%	77%	74%	76%

*2019 statewide rates are preliminary and may change slightly.

Child Survey Results

CAHPS Item	Rate Description	2016	2017	2018	2019*
Rating of Health Plan	% of Respondents rating their Health Plan an 8, 9, or 10 on a scale of 0-10	84%	86%	85%	85%
Getting Needed Care	% of Respondents reporting it is usually or always easy to get needed care	83%	83%	84%	**
Getting Care Quickly	% of respondents reporting it is usually or always easy to get care quickly	89%	89%	89%	89%
Customer Service	% of respondents reporting they usually or always get the help/info needed from their plan's customer service	88%	88%	90%	90%
Rating of Health Care	% of respondents rating their health care an 8, 9, or 10 on a scale of 0-10	86%	89%	87%	88%

*2019 statewide rates are preliminary and may change slightly.
**Excluded item due to only one Health Plan having sufficient survey responses to produce a reportable rate.

CMS-416 Child Check Up Reporting

The Agency submitted the finalized CMS-416 Report for Federal Fiscal Year (FFY) 2017-18 to CMS in the Spring of 2018. This report included the highest dental scores in the history of the Florida Medicaid program.

Highlights include:

38.6% of eligible children aged 1 through 20 years, enrolled for 90 continuous days, received a preventive dental health service; as calculated using the Child Core Set PDENT measure. This is a 1-percentage point increase from last year and a 19.6 percentage point increase from the FFY 2011-12 report.

More than 45% of eligible children accessed some form of oral health care through Florida Medicaid.

Please Note: This data only includes preventive dental services provided by a dentist. There is evidence, however, that many more children in Medicaid are receiving preventive dental services from registered dental hygienists operating in health access settings. Under Florida law, such hygienists bill separately for the services they provide, which include cleanings and sealants. Because of the specifications of the P-DENT measure, these services are not able to be captured.

Florida's Comprehensive Quality Strategy

The Comprehensive Quality Strategy (CQS) outlines Florida's strategy for assessing and improving the quality of health care and services furnished by the MMA plans and other providers within the Florida Medicaid system. The most recent draft of the CQS was submitted to CMS on March 3, 2017 (**Attachment IV**). The CQS is also available on the Agency's website:

http://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/Draft_full_Amended_012317.pdf

CQS Update:

The Agency began the process of updating the CQS during DY13, and will continue this process during DY14. The updated CQS will address various strategies to assess progress towards meeting the Agency's goals. The Agency's established goals seek to build upon the success of the SMMC program and to ensure that quality improvement is a continual process.

The Agency's goals include:

- Reducing potentially preventable hospital events, including admissions, readmissions, and emergency department visits;
- Improving birth outcomes, including primary C-section rate, pre-term birth rate, and rate of Neonatal Abstinence Syndrome; and
- Increasing the percentage of participants receiving long-term care services in their homes or within their communities opposed to an institutional care setting or nursing facility.

Another updated CQS will be submitted to CMS in the Spring of 2020.

External Quality Review

The Agency contracts with the Health Services Advisory Group (HSAG) as its External Quality Review Organization (EQRO) vendor. During DY13, HSAG submitted the following annual reports to the Agency.

- 2017-2018 Annual Technical Report (**Attachment V**)

  Across the three state-mandated performance improvement projects (PIPs), 73% of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. This included:

  1. Improving Timeliness of Prenatal Care and Well-Child Visits in the first 15 months of life (six or more visits),
  2. Preventive Dental Services for Children, and
  3. Medication Review PIPs.

- Performance Measure Validation Findings Report (**Attachment VI**)

Post Award Forum

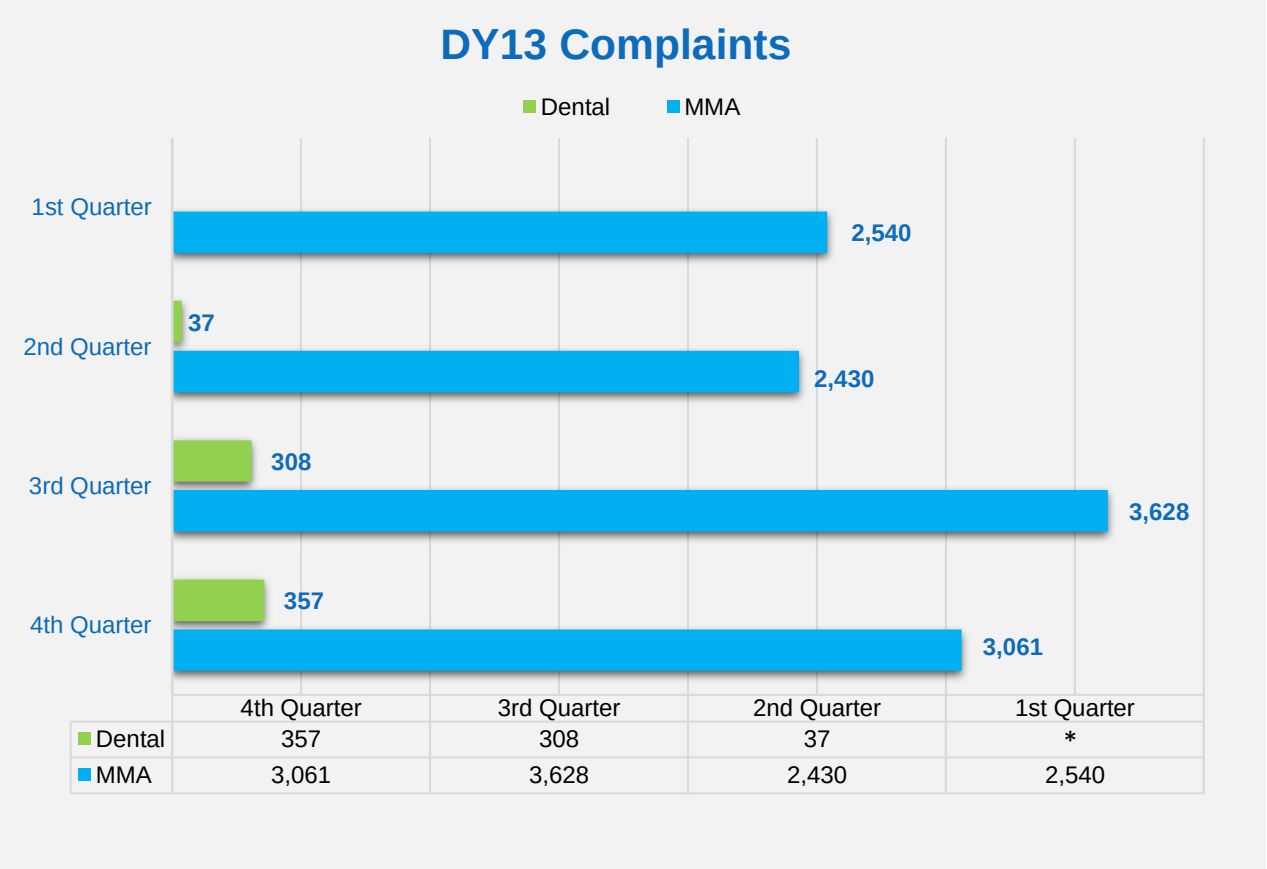
The annual post award public forum was conducted on December 11, 2018 during the Medical Care Advisory Committee meeting. The meeting was publicly noticed in the Florida Administrative Register on October 30, 2018. The Agency presented an overview of the MMA program, including information regarding amendments and key evaluation findings and accepted comments from the public.

Complaints, Grievances, and Appeals

Complaints Reported to the Agency

The Agency operates a centralized complaint operations center to resolve Medicaid complaints timely and to determine if plans are complying with the terms of their contracts. The Agency collects, aggregates, and trends the data for quality improvement initiatives.

The following graph details the complaints received by the Agency during DY13 by quarter, and the corresponding table represents the rate of complaints per 1,000 enrollees, for both the Dental and MMA programs. The table also contains the rate of complaints per 1,000 enrollees for DY12. DY13's rate of complaint decreased, both overall and quarterly, from DY12's rate. It is important to note that all complaints are captured, whether or not they were substantiated.



	4th Quarter	3rd Quarter	2nd Quarter	1st Quarter
Dental	357	308	37	*
MMA	3,061	3,628	2,430	2,540

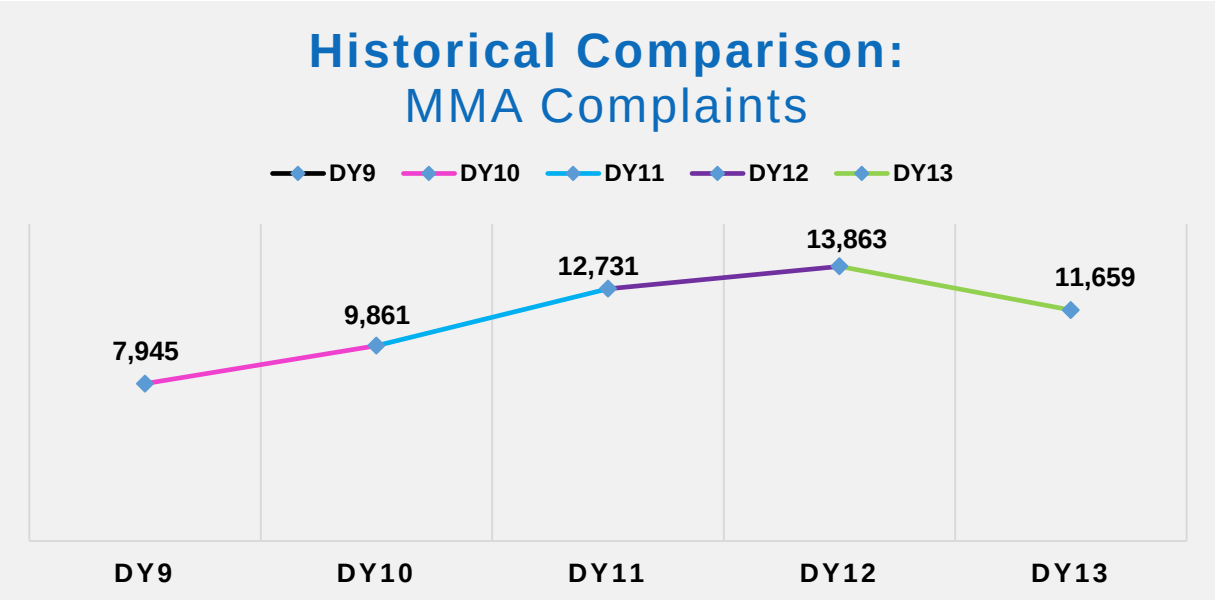
* Dental Plan enrollment began in December of 2018, which was the last month in the second quarter.

Complaints Received by the Agency per 1,000 Enrollees

DY13	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Dental Enrollment	Not Applicable	1,054,898	3,109,753	3,093,332
Dental Complaints	Not Applicable	37*	308	357
DY13 Complaints per 1000 Enrollees	**Not Applicable**	**.035**	**.099**	**.115**
MMA Enrollment	3,068,697	3,037,660	2,975,428	3,736,035
MMA Complaints	2,540	2,430	3,628	3,061
DY13 Complaints per 1000 Enrollees	**.828**	**.8**	**1.219**	**.819**
DY12 Complaints per 1000 Enrollees	.949	1.016	1.326	1.108

* Dental Plan enrollment began in December of 2018.

The graph below details the number of complaints received by the Agency for DY9 through DY13. As illustrated, the number of complaints received in DY13 has decreased from DY12, and marks the first demonstration year the complaint figure has decreased since the Managed Medical Assistance program went statewide. (There were 138 MMA complaints in Demonstration Year 8.)



Complaints, Grievances, and Appeals Reported to the MMA Plans

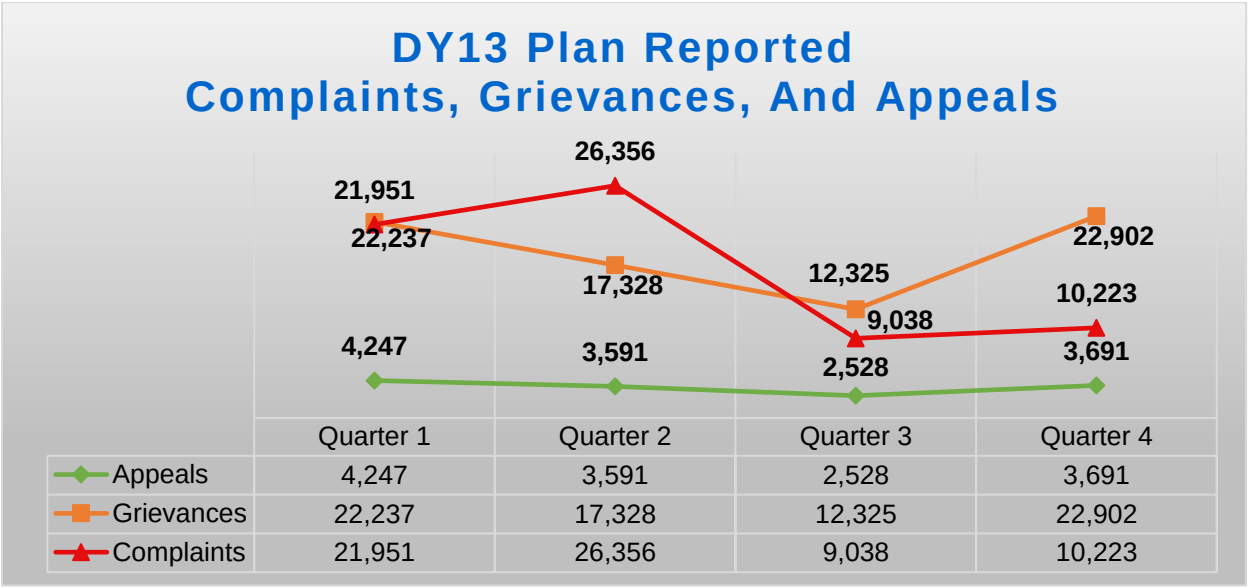
The MMA plans are required to report to the Agency all complaints, grievances, and appeals they receive monthly. Complaints, grievances, and appeals are defined in the MMA contracts as well as in the Code of Federal Regulations:

- Complaint - Any oral or written expression of dissatisfaction by an enrollee submitted to the MMA plan or to a State agency and resolved by close of business the following business day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or MMA plan employee, failure to respect the enrollee's rights, MMA plan administration, claims practices, or provision of services that relates to the quality of care rendered by a provider pursuant to the MMA plan's contract.
- Grievance - An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MMA plan to make an authorization decision.
- Appeal – A review of an adverse benefit determination

The report submitted to the Agency, must include new complaints received by the MMA plan during the reporting month as well as all pending complaints from previous reporting months.

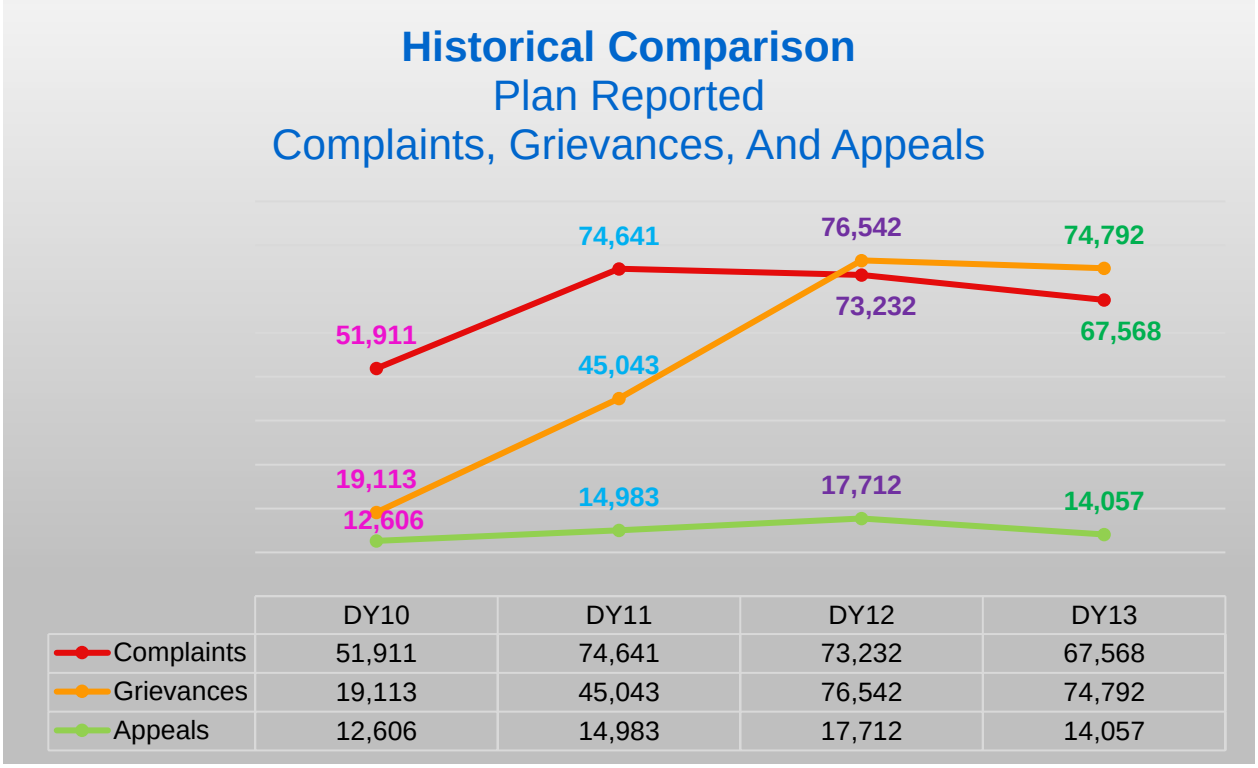
DY13 Complaints, Grievances, and Appeals

Complaints decreased in the third quarter after an increase during the second quarter. The number of grievances decreased during the first three quarters, and then spiked during the fourth quarter. The number of appeals during DY13 remained relatively stable with a steady decline until the fourth quarter.



	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Appeals	4,247	3,591	2,528	3,691
Grievances	22,237	17,328	12,325	22,902
Complaints	21,951	26,356	9,038	10,223

MMA plan reported complaints, grievances, and appeals all decreased in DY13 when compared to DY12, as the following chart demonstrates. Additionally, each of the three categories were lower in DY13 than they were in DY10, with the exception of grievances, which were higher in DY13.

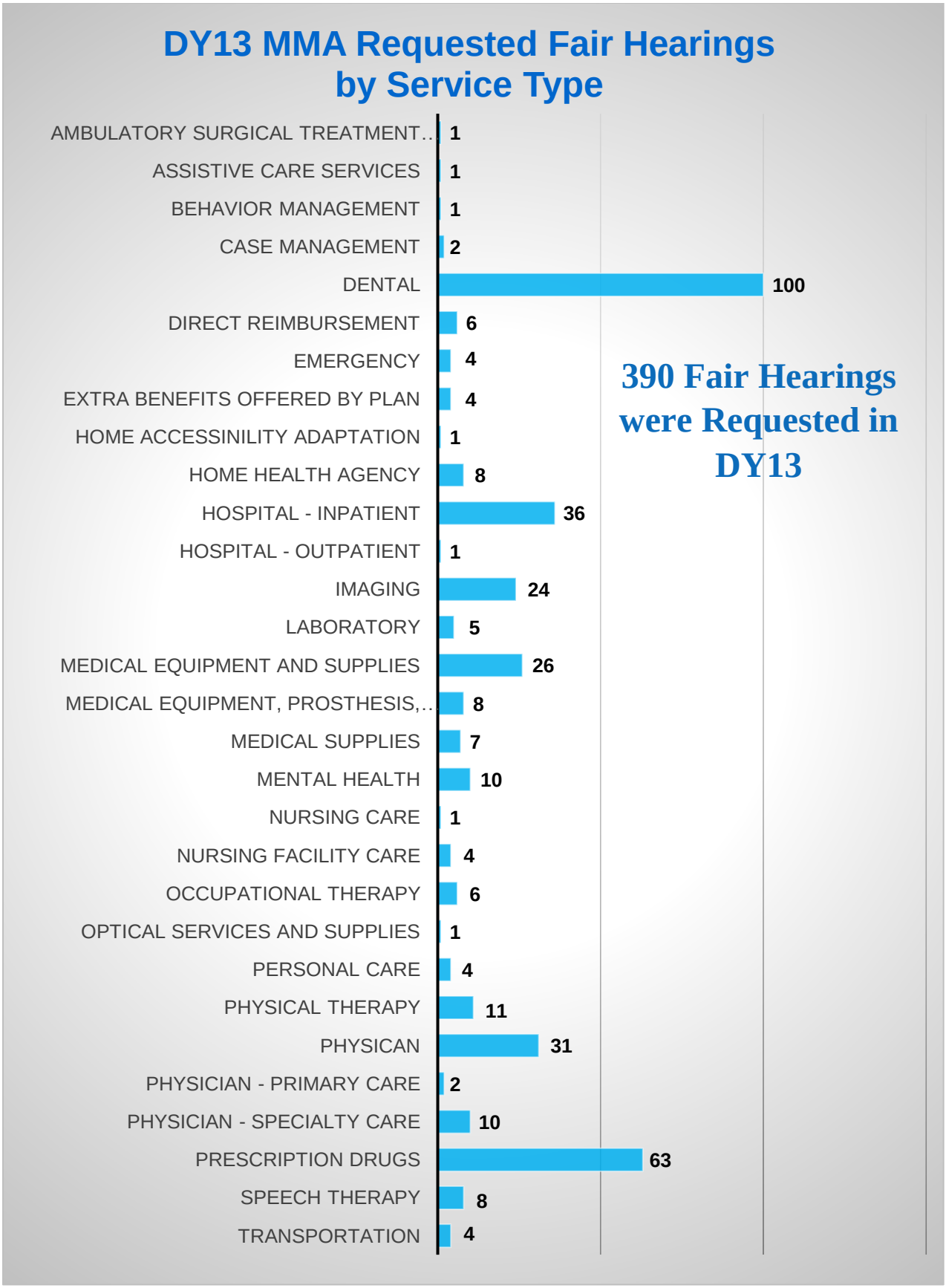


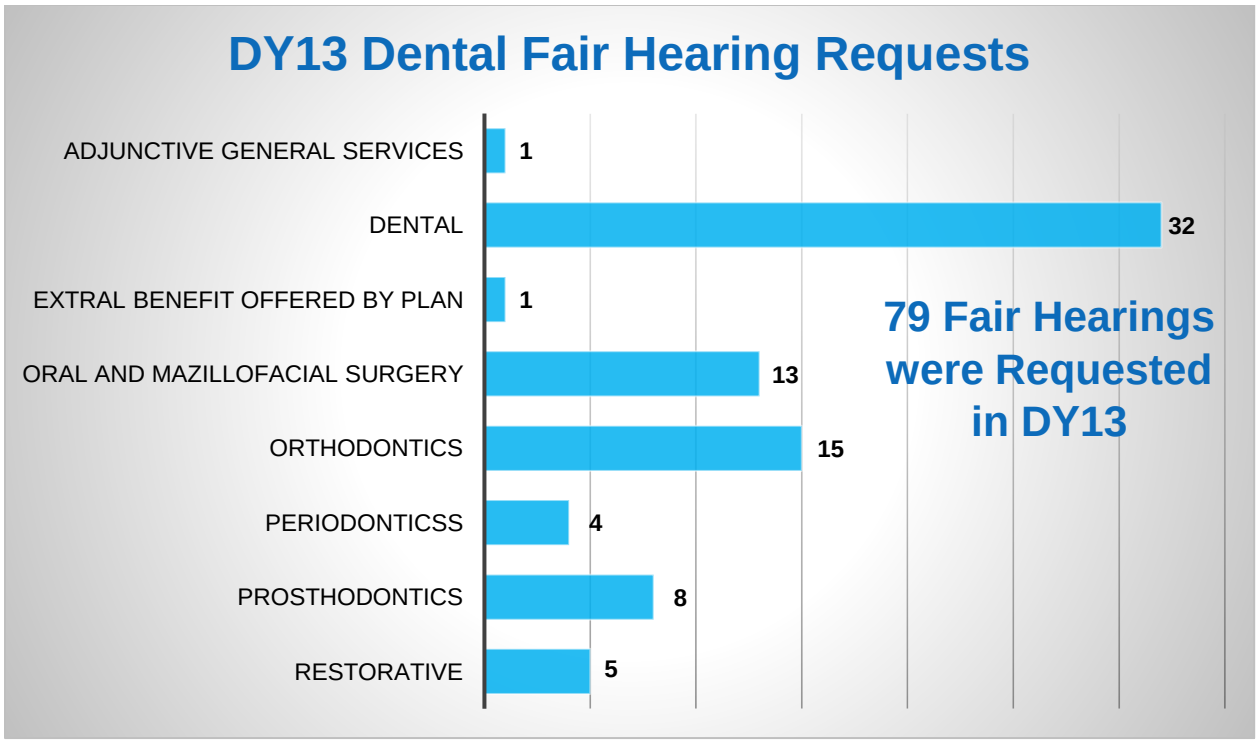
	DY10	DY11	DY12	DY13
Complaints	51,911	74,641	73,232	67,568
Grievances	19,113	45,043	76,542	74,792
Appeals	12,606	14,983	17,712	14,057

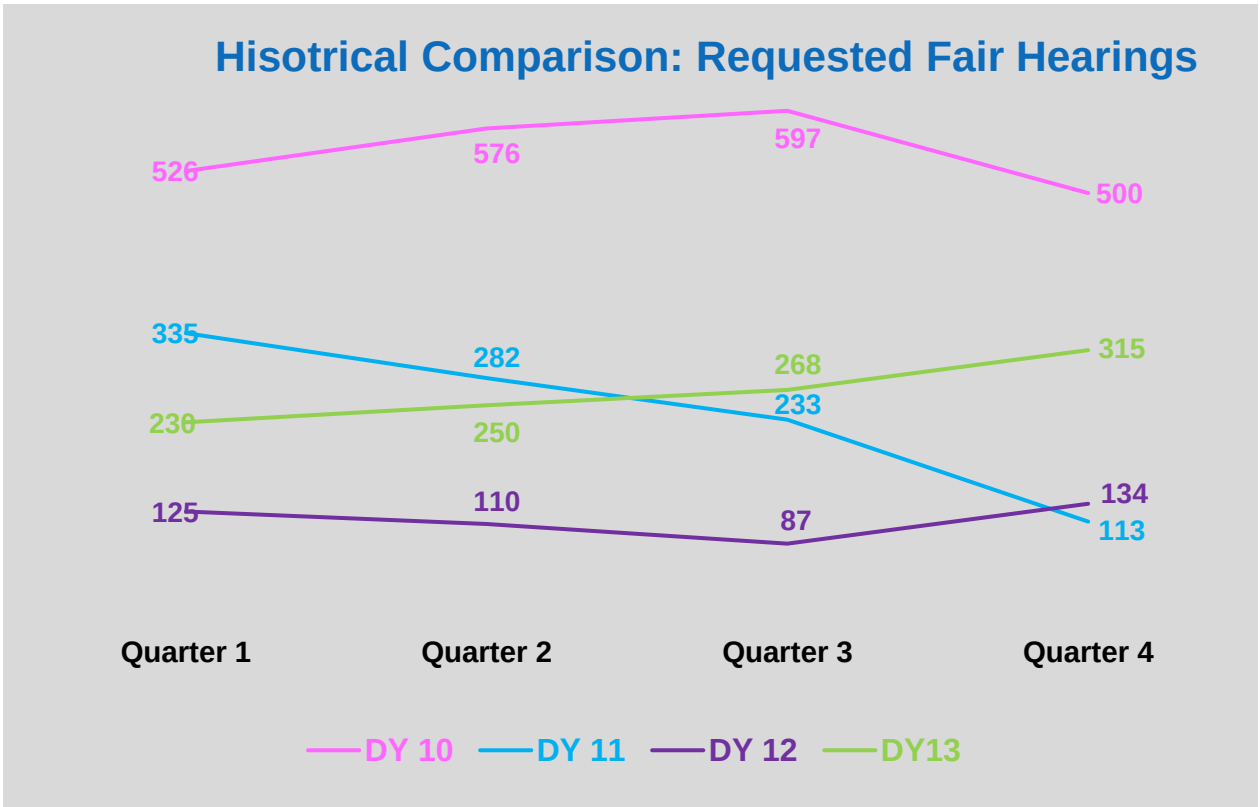
Fair Hearings

Fair Hearings may be requested when a recipient's claim for assistance or services is denied, reduced, suspended, or terminated by the Agency or the MMA plan, or if you disagree with the Agency's denial of a good cause MMA plan change request.

During DY13, there were a total of 469 fair hearings requested, 390 for the MMA plans and 79 for the dental plans. The requested fair hearings for both the MMA and dental plans are broken out by service type on the following pages.

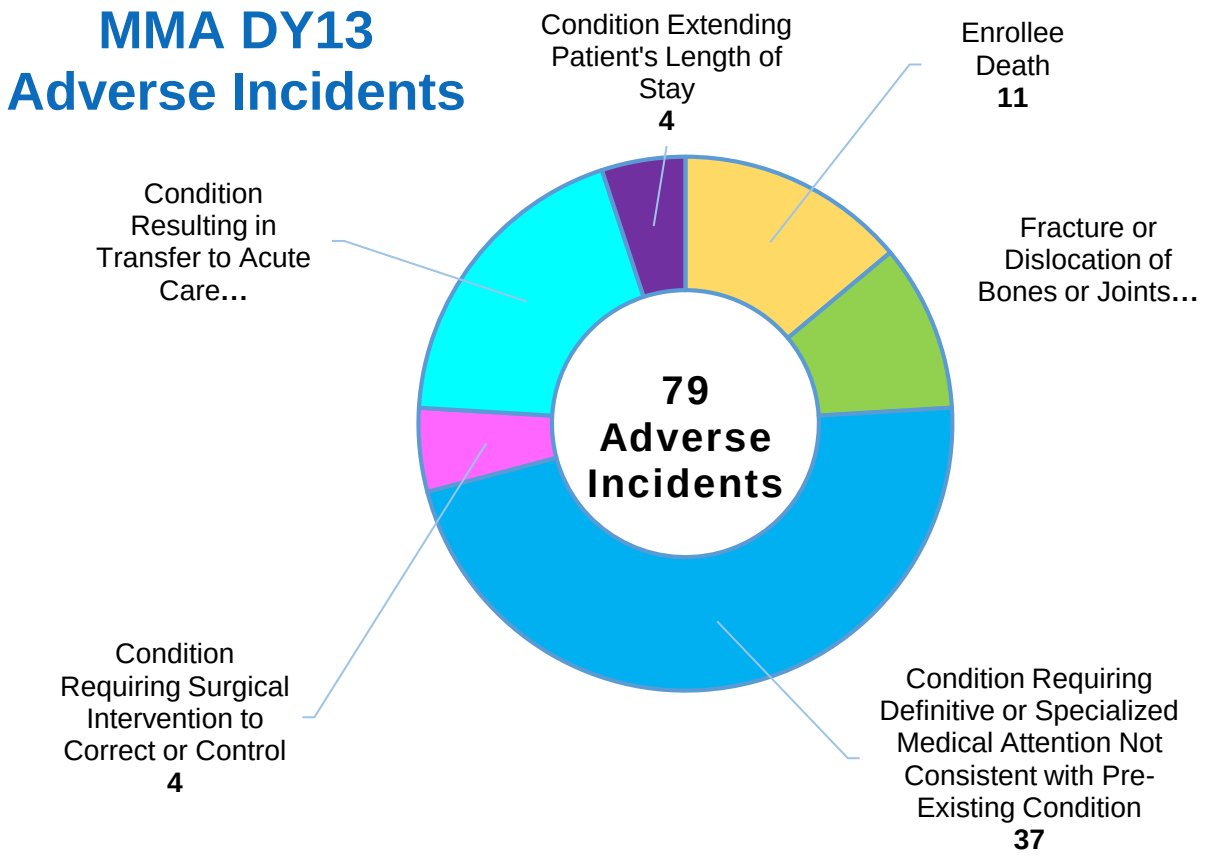

DY13 MMA Requested Fair Hearings by Service Type
AMBULATORY SURGICAL TREATMENT... 1
ASSISTIVE CARE SERVICES 1
BEHAVIOR MANAGEMENT 1
CASE MANAGEMENT 2
DENTAL 100
DIRECT REIMBURSEMENT 6
EMERGENCY 4
EXTRA BENEFITS OFFERED BY PLAN 4
HOME ACCESSINILITY ADAPTATION 1
HOME HEALTH AGENCY 8
HOSPITAL - INPATIENT 36
HOSPITAL - OUTPATIENT 1
IMAGING 24
LABORATORY 5
MEDICAL EQUIPMENT AND SUPPLIES 26
MEDICAL EQUIPMENT, PROSTHESIS,... 8
MEDICAL SUPPLIES 7
MENTAL HEALTH 10
NURSING CARE 1
NURSING FACILITY CARE 4
OCCUPATIONAL THERAPY 6
OPTICAL SERVICES AND SUPPLIES 1
PERSONAL CARE 4
PHYSICAL THERAPY 11
PHYSICAN 31
PHYSICIAN - PRIMARY CARE 2
PHYSICIAN - SPECIALTY CARE 10
PRESCRIPTION DRUGS 63
SPEECH THERAPY 8
TRANSPORTATION 4
390 Fair Hearings were Requested in DY13

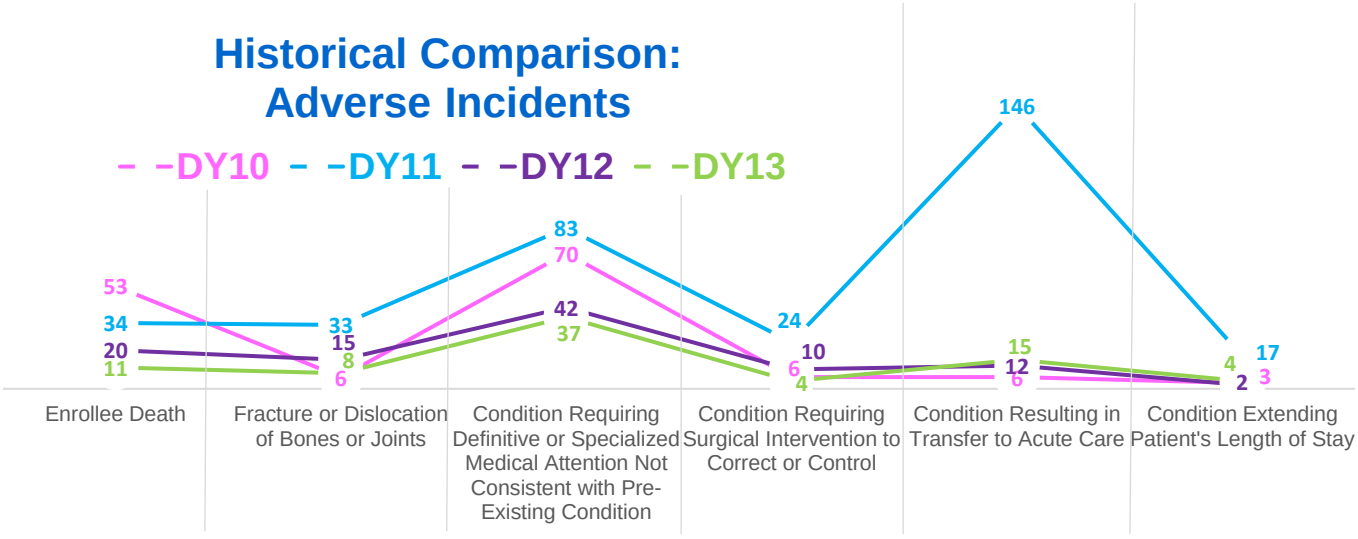

DY13 Dental Fair Hearing Requests
ADJUNCTIVE GENERAL SERVICES
1
DENTAL
32
EXTRAL BENEFIT OFFERED BY PLAN
1
ORAL AND MAZILLOFACIAL SURGERY
13
ORTHODONTICS
15
PERIODONTICSS
4
PROSTHODONTICS
8
RESTORATIVE
5
79 Fair Hearings were Requested in DY13


Hisotrical Comparison: Requested Fair Hearings
526
576
597
500
335
282
233
113
230
250
268
315
125
110
87
134
Quarter 1
Quarter 2
Quarter 3
Quarter 4
DY 10
DY 11
DY 12
DY13

Adverse Incident Reports

The Agency monitors adverse incidents and follows up with plans when it detects reporting anomalies or trends to determine what the issues are, and to obtain detailed information around those specific incidents. A total of 79 adverse incidents were reported during DY13; this is a 21.8% decrease from DY12.





Section III: Evaluation

Evaluation of the Demonstration

The demonstration evaluation is an ongoing process; it is conducted continuously throughout the Demonstration's approval period. Under STC 106, the Agency was required to complete a revised evaluation design, **Attachment VII**, to reflect the March 2019 amended STCs. The new evaluation design includes a discussion of the goals, objectives, and specific hypotheses being tested to determine the demonstration's impact during the approval period.

Evaluation Design DY13 (SFY2018-19)

Following the updated STC's implementation in March of 2019, Agency staff worked with the evaluators to update and revise the evaluation design to align with the new requirements. There were three stages to the evaluation design update.

The initial design included a discussion of goals, objectives, and specific testable hypotheses, including those that focus specifically on target populations for the demonstration, and more generally on recipients, providers, plans, market areas, and public expenditures. That version of the revised evaluation design was submitted to CMS on May 29, 2019.

The Agency later updated the evaluation design to include Component 9: The impact of the waiver of retroactive eligibility on beneficiaries and providers.

For the final design, Agency staff again worked with the evaluation team to update the evaluation design to include Component 10. Component 10 is the impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability. This final evaluation design was submitted to CMS in July 2019.

Summary of Waiver Evaluation Activities DY13 (SFY 2018-19)

- The Agency provided DY11 (SFY16-17) data to the evaluators in July 2018.
- In September 2018, the evaluators presented their evaluation findings for DY9 and DY10 at Agency headquarters.
- The evaluators submitted the draft and final DY11 evaluation reports for Components 1-7 during the Spring of 2019.
- The Agency began working with the evaluators in June 2019 to create a survey to administer to hospital and nursing facility personnel regarding the retroactive eligibility policy change (Component 9).
- An amendment to the contract (Amendment 4) was executed June 28, 2019. The amendment renewed the evaluation through June 30, 2022.

DY11 Final Reports: Findings

The Demonstration Evaluation Report for DY11 was finalized in 2019. The results are summarized below.

Project 1: Access, Use, Cost, and Quality of Care (Components 1, 2, 5, and 7)

- Performance on HEDIS measures related to access and quality of care remained relatively stable between CY 2016 and 2017; although, two measures related to access noticeably improved: Adult's Access to Preventive/Ambulatory Services for enrollees over the age of 65 (80 percent in CY 2016 to 90 percent in CY2017) and Well Child Visits in the First 15 Months of Life (63 percent in CY 2016 to 70 percent in CY2017).
- Performance on CAHPS measures related to access and quality of care were stable between DY10 and DY11 for both adults and children.
- Similar to DY10, the percentage of primary care physicians that did not meet contractual wait-time requirements in DY11 was 5.6 percent for urgent care, 6.7 percent for routine care, and 1.1 percent for well care.
- After adjusting for demographic characteristics and health status, reductions were seen in the mean number of all services – inpatient stays, outpatient visits, emergency department (ED) visits, and professional visits – between the two years prior to MMA (pre-MMA) and MMA period.
- Average per member per month expenditures continue to be lower in the MMA period compared to the pre-MMA period.
- 66.3 percent of the 3,353,163 MMA enrollees who used any service in DY11 used expanded benefits.
- Of the 277,637 new individual enrollees, 80.85 percent (N=224,472[1]) were enrolled under Express Enrollment using auto-enrollment, compared with 19.15 percent (N=53,165) who were enrolled by voluntary choice.
- The average number of days for a new enrollee to access services under express enrollment was 86.10 days for those who were auto-enrolled, versus 45.24 days for those who made a voluntary choice for enrollment in DY11.

Project 2: Health Behaviors Programs (Component 3)

- A total of 11 different types of Healthy Behaviors programs are offered across Florida's 16 MMA plans in addition to the three medically approved mandatory programs (Smoking Cessation, Weight Loss, and Alcohol/Substance Abuse Recovery).

[1] The total number of new enrollees who were auto-enrolled.

- Of the mandatory programs, the medically-directed weight loss program reported the highest number of current enrollees (31,273), as well as the highest number of enrollees who completed the program (658).
- Out of all Healthy Behaviors programs, the well-child visits program had the highest number of enrollees who completed the program (124,608), followed by the dental program (58,273).
- Among the mandatory programs, women were more likely than men to be currently enrolled in and to have completed the programs. For example, among all plans reported, approximately 65 percent of enrollees in the medically approved smoking cessation program were women and about 35 percent were men.

Project 3: Low Income Pool (LIP) (Component 4)

- In DY11, 157 hospitals received a total of approximately $577 million in LIP supplemental payments for providing services to uncompensated charity care individuals.
- In DY11, out of approximately 7.5 million total service encounters, the three services with the greatest number of encounters for uncompensated charity care patients across all tiers were:

    1. Emergency room visits - 2.1 million total encounters
    2. Inpatient days - 1.9 million total encounters
    3. Outpatient visits - 1.5 million total encounters

Project 4: Dual-Eligible Enrollees (Component 6)

- Dual-eligible users are using fewer behavioral health (BH) services and those services have lower costs per service compared to non-dual-eligible users.
- Dual-eligible enrollees are using more non-emergency transportation (NET) services, but those services have lower costs per user compared to non-dual-eligible users.
- Telephone surveys revealed that dual-eligible enrollees had generally positive experiences and satisfaction with the BH and NET services provided by MMA plans. Enrollees are generally getting the BH care they need and reporting positively about communication with their BH service provider. Some areas for improvement include ensuring that needed BH services are fully covered by health plans (which may involve better coordination with Medicare plans), helping specialty plan members receive BH services when health plan approval is needed, and improving the timeliness of NET services in picking up enrollees after their scheduled appointments.

MMA Plan Monitoring

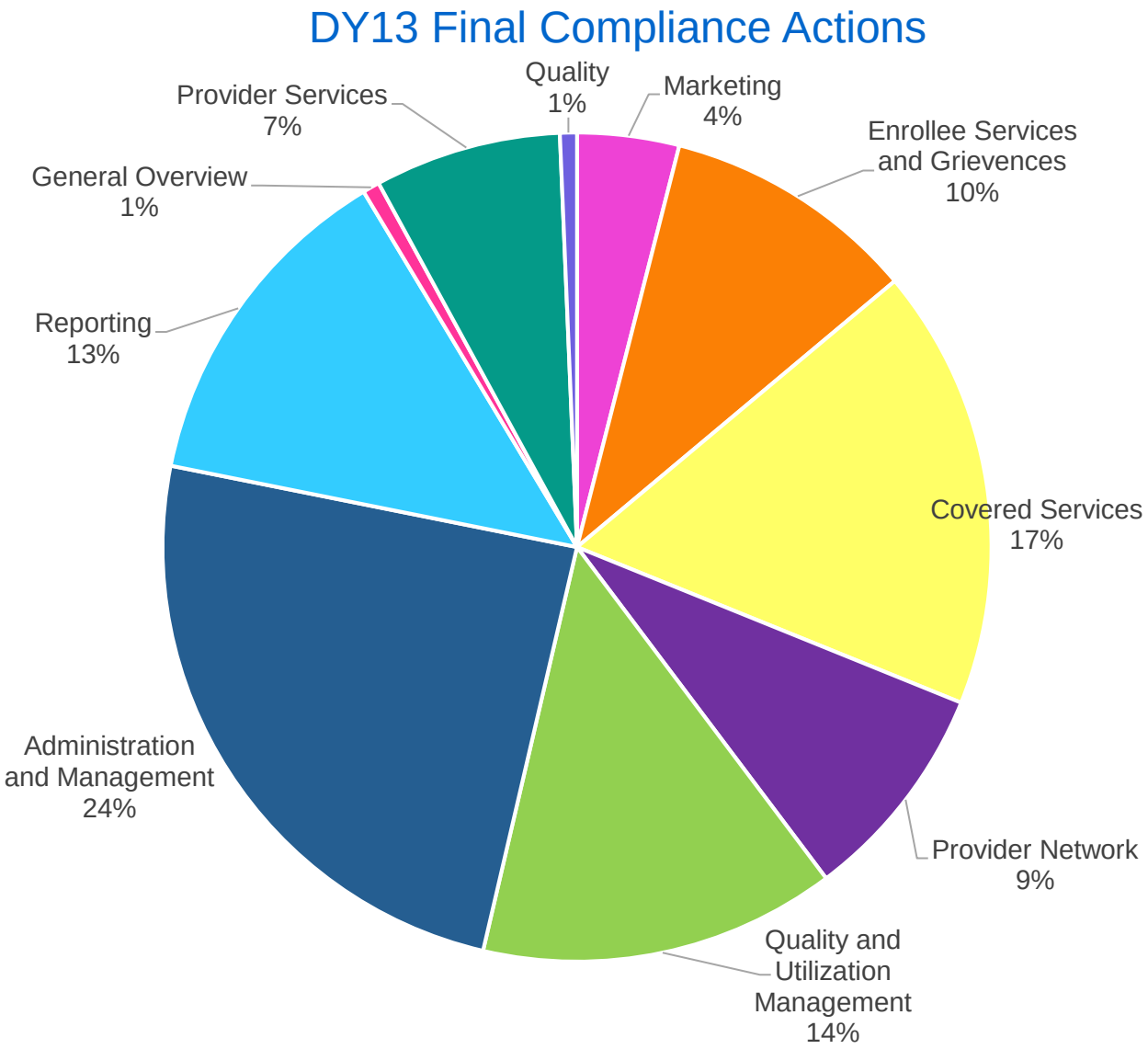
Plan Compliance

The Agency monitors the MMA plans' performance through a variety of mechanisms including plan reports and submissions, desk and on-site compliance reviews, and reviews of complaints and grievances.

The Agency provides oversight in all aspects of plan operations and may take the following compliance actions when plans fail to meet requirements specified in their contract:

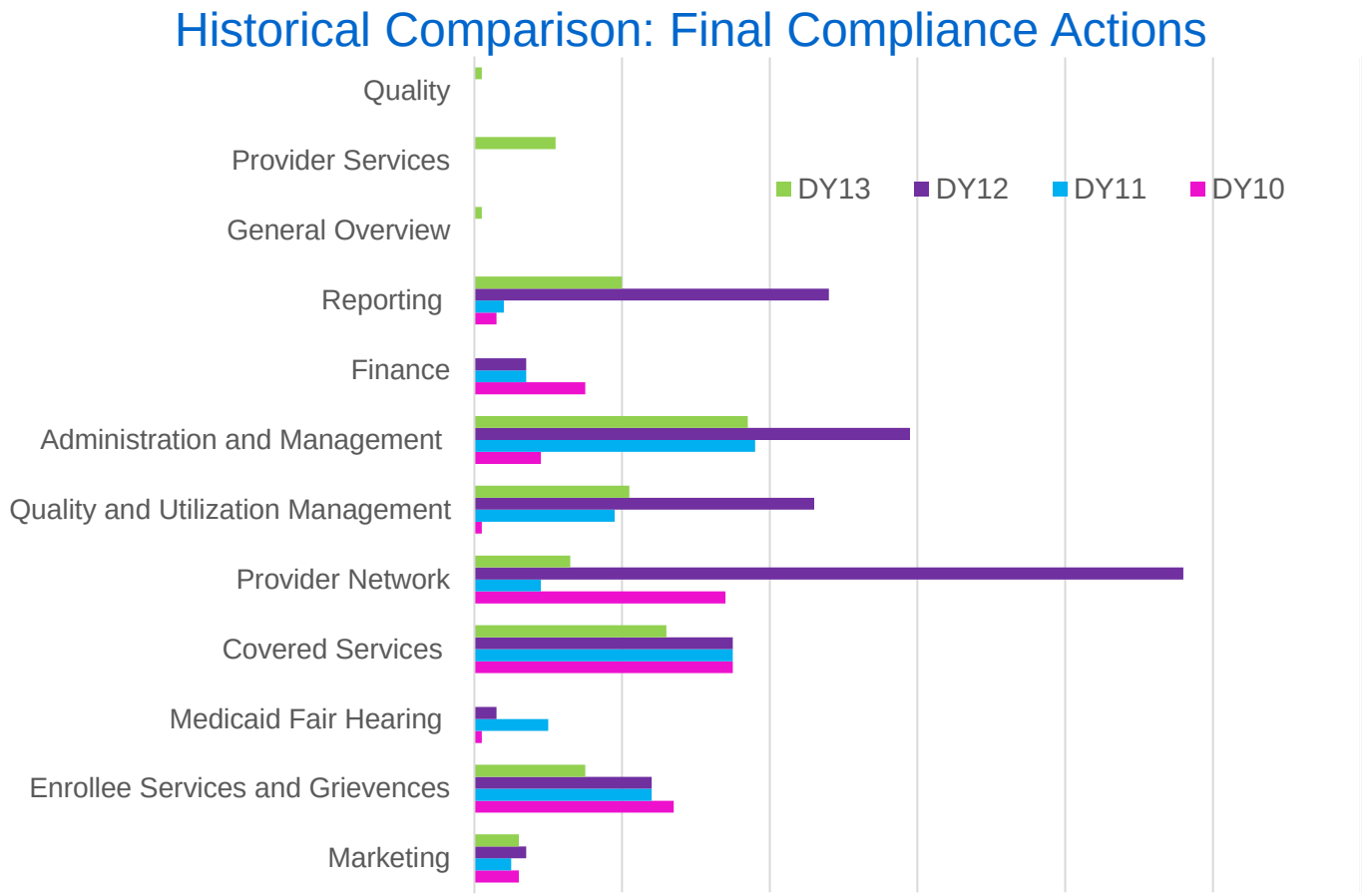
- **Corrective Action Plan:** A plan submitted to the Agency, outlining how the managed care plan will remedy an area of non-compliance.
- **Liquidated Damages:** A monetary charge to the plan. Liquidated damages are not intended to be a penalty, but rather a reasonable estimate of the Agency's projected financial loss and damage resulting from the managed care plan's non-performance, including financial loss as a result of program delays.
- **Sanction:** Monetary or non-monetary action, including, but not limited to enrollment freezes or temporary Agency management of the managed care plan.

In DY13, the Agency took 151 final compliance actions. The most prevalent areas of MMA plan non-compliance, with number of occurrences exceeding 20, in DY13 were administration and management, covered services, and quality and utilization management.



Area of Non-Compliance	Occurrences
Marketing	6
Enrollee Services and Grievances	15
Covered Services	26
Provider Network	13
Quality and Utilization Management	21
Administration and Management	37
Reporting	20
General Overview	1
Provider Services	11
Quality	1
Total	***151***

As the graph and chart below illustrate, over the past four demonstration years, final actions for non-compliance were highest for MMA plan administration and management as well as for covered services. While this pattern held true in DY13, the total number of final actions for non-compliance the Agency took in DY13 decreased from DY12, to match the number of final actions taken in DY11.



Area of Non-Compliance	**DY10**	**DY11**	**DY12**	**DY13**
Marketing	6	5	7	6
Enrollee Services and Grievances	27	24	24	15
Medicaid Fair Hearing	1	10	3	
Covered Services	35	35	35	26
Provider Network	34	9	96	13
Quality and Utilization Management	1	19	46	21
Administration and Management	9	38	59	37
Finance	15	7	7	
Reporting	3	4	48	20
General Overview				1
Provider Services				11
Quality				1
Totals	**131**	**151**	**325**	**151**

Section IV: Financial Reporting Requirements and Budget Neutrality

Medical Loss Ratio (MLR)

The Agency evaluates the MMA Plans' MLR annually to determine compliance. In addition to the annual MLR evaluation, quarterly reports are also provided by the MMA plans for Agency monitoring. Specifically, quarterly reports are monitored for seasonal and inherent claim volatility, which may cause the MLR results to fluctuate somewhat from quarter to quarter; especially for smaller plans.

MLR results are subject to Agency review and MMA plan resubmissions of underlying MLR data.

The MMA Plans reported the annual Medical Loss Ratio (MLR) for calendar year 2018 during DY13. All of the MMA Plans reported an MLR greater than or equal to the required 85% threshold; however, three MMA Plans reported a MLR greater than 95%.

Plan Type	MMA Plan Name	Capitation Paid Less Fed/State Taxes/Fees	Total Expenses	Funds and Cont.	Capitation - Total Expenses	Medical Loss Ratio	Difference
Standard MMA Plans	Amerigroup Florida, Inc.	$1,022,584,840	$994,430,415	$0	$28,154,425	97.25%	12.25%
	Better Health, Inc.	$275,216,657	$248,428,547	$0	$26,788,110	90.27%	5.27%
	Humana Medical Plan, Inc.	$1,104,069,953	$985,223,090	$0	$118,846,863	89.24%	4.24%
	Molina Healthcare of Florida, Inc.	$1,237,818,143	$1,093,202,980	$0	$144,615,163	88.32%	3.32%
	Prestige Health Choice	$1,174,131,177	$1,123,527,112	$0	$50,604,064	95.69%	10.69%
	Simply Healthcare Plans, Inc.	$370,758,190	$336,616,616	$0	$34,141,574	90.79%	5.79%
	Sunshine State Health Plan, Inc.	$1,839,909,193	$1,735,790,060	$0	$104,119,133	94.34%	9.34%
	United Healthcare of Florida, Inc.	$1,013,690,420	$939,581,733	$0	$74,108,687	92.69%	7.69%
	WellCare of Florida dba StayWell	$2,260,831,333	$2,031,213,339	$0	$229,617,994	89.84%	4.84%
Standard Plans < 50,000	Community Care Plan	$136,587,351	$125,781,120	$0	$10,806,231	92.09%	7.09%
	Coventry Health Care of Florida, Inc.	$187,790,425	$165,789,982	$0	$22,000,444	88.28%	3.28%
Specialty Plans	Clear Health Alliance	$249,678,958	$230,071,484	$0	$19,607,474	92.15%	7.15%
	Positive Healthcare	$50,602,364	$49,447,446	$0	$1,154,918	97.72%	12.72%
	Magellan Complete Care	$583,537,829	$529,199,590	$0	$54,338,240	90.69%	5.69%
	Grand Total	$11,507,206,831	$10,588,303,513	$0	$918,903,318	92.01%	7.01%

The Agency is monitoring the MMA plans that reported an MLR at or above 95%, as highlighted in the table above, for financial performance; these plans include Amerigroup Florida, Inc., which reported an MLR at 97.25%, Prestige Health Choice at 95.69%, and Positive Healthcare at 97.72%.

1. Amerigroup Florida, Inc.

   As of December 31, 2018, Amerigroup Florida Inc. reported its MLR at 97.25%. The total operating loss was -$68,329,977 and the operating margin was reported at -6.73%.

   Amerigroup Florida, Inc. merged with Simply Healthcare Plans, Inc. Amerigroup's SMMC contract terminated in December 2018 when the new SMMC contracts were effective, and Amerigroup Florida, Inc.'s membership was rolled over to Simply Healthcare Plans, Inc., which was awarded a 2018-2023 SMMC contract.

2. Prestige Health Choice

   As of December 31, 2018, Prestige Health Choice reported an MLR at 95.69%. The total operating loss was -$100,210,948 and the operating margin was reported at -8.59%.

   Prestige Health Choice operated in 8 Medicaid regions during the 2014-2018 SMMC contract period and was awarded a Managed Medical Assistance contract in 2 regions for the 2018-2023 SMMC contract period.

3. Positive Healthcare

   As of December 31, 2018, Positive Healthcare reported an MLR at 97.72%. The total operating loss was -$3,703,684 and the operating margin was reported at -7.32%.

   Positive Healthcare is now part of Simply Healthcare Plans, Inc.

Factors that may have contributed to these MMA plans having an MLR over 95% are, the inclusion of Incurred but Not Reported (IBNR) expenses in the MLR calculation, due to three months of claim runouts, as well as the inclusion of expanded benefits, which are offered at the MMA plan's discretion, over and above State Plan services.

Encounter Data Activities

During DY13, the Agency continues to work with the plans to improve encounter acceptance rates. Routine on-line and in-person meetings provide a platform for both the Agency and the plans to provide feedback regarding the process.

In January 2019, the Agency implemented the new Health Plan Portal. This portal grants plans access to view encounter data contained within the Florida Medicaid Management Information System.

The portal also includes Encounter Dashboards. These dashboards display encounter timeliness and accuracy compliance percentages and trends. The encounter accuracy reports were improved and implemented in April 2019.

Encounter Accuracy Reports are sent to the plans weekly and include supplemental reports that show the encounter submissions that were denied and the reason for the denials.

The dissemination of these reports has proved to be beneficial in disseminating information to the plans, and the easy to use platform for information has assisted the plans in determining where encounter submission improvements need to implemented.

Budget Neutrality

In Tables A through I, both the date of service and date of payment data are presented. Tables that provide data on a quarterly basis (Tables B & C) reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

The Agency certifies the accuracy of the member months identified in Tables B through I, in accordance with STC #77(d).

Table A shows the Per Member Per Month (PMPM) cap established in the MMA Waiver as specified in STC #93(b). These caps are compared to actual waiver expenditures using date of service tracking and reporting.

TABLE A		
PMPM Targets		
WOW[2] PMPM	**MEG 1**	**MEG 2**
DY1	$948.79	$199.48
DY2	$1,024.69	$215.44
DY3	$1,106.67	$232.68
DY4	$1,195.20	$251.29
DY5	$1,290.82	$271.39
DY6	$1,356.65	$285.77
DY7	$1,425.84	$300.92
DY8	$1,498.56	$316.87
DY9	$786.70	$324.13
DY10	$830.22	$339.04
DY11	$876.81	$354.64
DY12	$1,027.49	$267.77
DY13	$1,068.59	$280.09
DY14	$1,111.33	$292.97
DY15	$1,155.78	$306.45
DY16	$1,202.01	$320.55

The quarter beginning October 2014 (Q34 - date of payment) is the first complete quarter under the MMA program. Historical data prior to this quarter is available upon request.

Tables B through I, contain the statistics for Medicaid Eligibility Groups (MEGs) 1, 2, 3, 4, 5, 6, and 7 for date of payment beginning through June 30, 2019. Member months (MM) provided in Tables B, C, and F for MEGs 1, 2, and 4 are actual eligibility counts as of the last day of each quarter. The expenditures provided are recorded on a cash basis for the month paid.

[2] Without Waiver

TABLE B MEG 1 Statistics: SSI Related				
DY/Quarter	**Actual MEG 1**	**Member Months**	**Total Spend***	**PMPM**
DY09/Q34	Oct-Dec 2014	1,500,372	$1,307,504,932	$871.45
DY09/Q35	Jan-Mar 2015	1,462,357	$1,134,356,032	$775.70
DY09/Q36	Apr-Jun 2015	1,337,626	$999,171,844	$746.97
DY10/Q37	Jul-Sep 2015	1,596,204	$1,154,199,030	$723.09
DY10/Q38	Oct-Dec 2015	1,604,502	$1,211,850,145	$755.28
DY10/Q39	Jan-Mar 2016	1,616,079	$1,247,196,020	$771.74
DY10/Q40	Apr-Jun 2016	1,673,703	$1,268,969,637	$758.18
DY11/Q41	July-Sep 2016	1,663,286	$1,410,409,589	$847.97
DY11/Q42	Oct-Dec 2016	1,664,558	$1,440,904,934	$865.64
DY11/Q43	Jan-Mar 2017	1,652,117	$1,435,824,785	$869.08
DY11/Q44	Apr-Jun 2017	1,630,929	$1,452,423,483	$890.55
DY12/Q45	Jul-Sep 2017	1,611,019	$1,480,123,488	$918.75
DY12/Q46	Oct-Dec 2017	1,601,642	$1,435,111,963	$896.03
DY12/Q47	Jan-Mar 2018	1,596,747	$1,470,691,952	$921.06
DY12/Q48	Apr-Jun 2018	1,663,494	$1,360,912,475	$818.10
DY13/Q49	Jul-Sep 2018	1,578,034	$ 1,357,624,242	$860.33
DY13/Q50	Oct-Dec 2018	1,663,309	$ 1,383,197,372	$831.59
DY13/Q51	Jan-Mar 2019	1,629,631	$ 1,374,641,026	$843.53
DY13/Q52	Apr-Jun 2019	1.630,175	$ 1,174,522,858	$720.49
	Managed Medical Assistance- MEG 1 Total[3]	**59,005,820**	**$29,865,517,174**	**$936.63**

* For Tables B and C, the quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 report submissions without the adjustment of rebates.

[3] MMA MEG1 Totals (from DY01 on)

TABLE C MEG 2 Statistics: Children and Families				
DY/Quarter	**Actual MEG 2**	**member months**	**Total Spend***	**PMPM**
DY09/Q34	Oct-Dec 2014	6,858,360	$1,997,982,421	$291.32
DY09/Q35	Jan-Mar 2015	7,294,147	$1,720,540,183	$235.88
DY09/Q36	Apr-Jun 2015	6,479,912	$1,461,749,214	$225.58
DY10/Q37	Jul-Sep 2015	7,370,555	$1,751,656,163	$237.63
DY10/Q38	Oct-Dec 2015	7,489,852	$2,166,649,322	$289.28
DY10/Q39	Jan-Mar 2016	7,547,248	$1,921,711,711	$254.62
DY10/Q40	Apr-Jun 2016	7,650,908	$1,935,227,890	$252.94
DY11/Q41	July-Sep 2016	7,701,261	$1,806,700,651	$234.60
DY11/Q42	Oct-Dec 2016	7,692,285	$2,213,198,925	$287.72
DY11/Q43	Jan-Mar 2017	7,718,856	$2,095,819,000	$271.52
DY11/Q44	Apr-Jun 2017	7,714,538	$2,141,370,706	$277.58
DY12/Q45	Jul-Sep 2017	7,525,304	$1,929,779,887	$256.44
DY12/Q46	Oct-Dec 2017	7,475,495	$2,074,732,467	$277.54
DY12/Q47	Jan-Mar 2018	7,387,879	$2,043,157,742	$276.56
DY12/Q48	Apr-Jun 2018	7,342,683	$2,074,948,180	$282.59
DY13/Q49	Jul-Sep 2018	7,132,311	$1,946,792,330	$272.95
DY13/Q50	Oct-Dec 2018	7,124,805	$2,310,894,150	$324.34
DY13/Q51	Jan-Mar 2019	7,057,761	$2,056,760,476	$291.42
DY13/Q52	Apr-Jun 2019	6,957,517	$2,291,231,181	$329.32
	Managed Medical Assistance- MEG 2 Total[4]	**307,038,199**	**$40,990,999,464**	**$216.38**

Tables D and E provide cumulative expenditures and member months for the reporting period for each demonstration year. The combined PMPM is calculated by weighting MEGs 1 and 2 using the actual member months. In addition, the PMPM targets, as provided in the STCs, are also weighted using the actual member months.

[4] MMA MEG2 Total (from DY01 on)

TABLE D MEG1 and MEG2 Annual Statistics			
DY09– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY09 Total	5,326,173	$4,235,554,765	$795.23
WOW DY09 Total	5,326,173	$4,190,100,299	$786.70
Difference		$45,454,466	
% of WOW PMPM MEG 1			101.08%
DY09– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY09 Total	27,169,344	$6,171,352,881	$227.14
WOW DY09 Total	27,169,344	$8,806,399,471	$324.13
Difference		$(2,635,046,589)	
% of WOW PMPM MEG 2			70.08%
DY10– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY10 Total	6,490,488	$4,871,467,423	$750.55
WOW DY10 Total	6,490,488	$5,388,532,947	$830.22
Difference		$(517,065,524)	
% of WOW PMPM MEG 1			90.40%
DY10– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY10 Total	30,058,563	$7,783,980,294	$258.96
WOW DY10 Total	30,058,563	$10,191,055,200	$339.04
Difference		$(2,407,074,906)	
% of WOW PMPM MEG 2			76.38%
DY11– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY11 Total	6,610,890	$5,774,063,463	$873.42
WOW DY11 Total	6,610,890	$5,796,494,461	$876.81
Difference		$(22,430,998)	
% of WOW PMPM MEG 1			99.61%
DY11– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY11 Total	30,826,940	$8,312,799,101	$269.66
WOW DY11 Total	30,826,940	$10,932,466,002	$354.64
Difference		$(2,619,666,900)	
% of WOW PMPM MEG 2			76.04%
DY12– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY12 Total	6,472,902	$5,712,245,353	$882.49
WOW DY12 Total	6,472,902	$6,650,842,076	$1,027.49
Difference		$(938,596,723)	
% of WOW PMPM MEG 1			85.89%
DY12– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY12 Total	29,731,361	$8,141,096,039	$273.82
WOW DY12 Total	29,731,361	$7,961,166,535	$267.77
Difference		$179,929,504	
% of WOW PMPM MEG 2			102.26%
DY13– MEG 1	**Actual MM**	**Total**	**PMPM**
MEG 1 – DY13 Total	6,501,149	$5,139,876,607	$790.61
WOW DY13 Total	6,501,149	$6,947,062,810	$1,068.59
Difference		$(1,807,186,203)	
% of WOW PMPM MEG 1			73.99%
DY13– MEG 2	**Actual MM**	**Total**	**PMPM**
MEG 2 – DY13 Total	28,272,394	$8,416,081,633	$297.68
WOW DY13 Total	28,272,394	$7,918,814,835	$280.09
Difference		$497,266,798	
% of WOW PMPM MEG 2			106.28%

For DY9, MEG 1 has a PMPM of $795.23 (Table D), compared to WOW of $786.70 (Table A), which is 101.08% of the target PMPM for MEG 1. MEG 2 has a PMPM of $227.14 (Table D), compared to WOW of $324.13 (Table A), which is 70.08% of the target PMPM for MEG 2.

For DY10, MEG 1 has a PMPM of $750.55 (Table D), compared to WOW of $830.22 (Table A), which is 90.40% of the target PMPM for MEG 1. MEG 2 has a PMPM of $258.96 (Table D), compared to WOW of $339.04 (Table A), which is 76.38% of the target PMPM for MEG 2.

For DY11, MEG 1 has a PMPM of $873.42 (Table D), compared to WOW of $876.81 (Table A), which is 99.61% of the target PMPM for MEG 1. MEG 2 has a PMPM of $269.66 (Table D), compared to WOW of $354.64 (Table A), which is 76.04% of the target PMPM for MEG 2.

For DY12, MEG 1 has a PMPM of $882.49 (Table D), compared to WOW of $1,027.49 (Table A), which is 85.89% of the target PMPM for MEG 1. MEG 2 has a PMPM of $273.82 (Table D), compared to WOW of $267.77 (Table A), which is 102.26% of the target PMPM for MEG 2.

For DY13, MEG 1 has a PMPM of $790.61 (Table D), compared to WOW of $1,068.59 (Table A), which is 73.99% of the target PMPM for MEG 1. MEG 2 has a PMPM of $297.68 (Table D), compared to WOW of $280.09 (Table A), which is 106.28% of the target PMPM for MEG 2.

TABLE E
Managed Medical Assistance Cumulative Statistics

DY 09	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	32,495,57	$10,406,907,646	$320.26
WOW	32,495,57	$12,996,499,70	$399.95
Difference		$(2,589,592,124)	
% Of WOW			80.07%
DY 10	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	36,549,051	$12,655,447,716	$346.26
WOW	36,549,051	$15,579,588,147	$426.27
Difference		$(2,924,140,431)	
% Of WOW			81.23%
DY 11	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	37,437,830	$14,086,862,564	$376.27
WOW	37,437,830	$16,728,960,463	$446.85
Difference		$(2,642,097,898)	
% Of WOW			84.21%
DY 12	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	36,204,263	$13,853,341,392	$382.64
WOW	36,204,263	$14,612,008,611	$403.60
Difference		$(758,667,219)	
% Of WOW			94.81%
DY 13	**Actual MM**	**Total**	**PMPM**
Meg 1 & 2	34,773,543	$13,555,958,240	$389.84
WOW	34,773,543	$14,865,877,645	$427.51
Difference		$(1,309,919,406)	
% Of WOW			91.19%

For DY9, the weighted target PMPM for the reporting period using the actual member months and the MEG specific targets in the STCs (Table E) is $399.95. The actual PMPM weighted for the reporting period using the actual member months and the MEG specific actual PMPM as provided in Table E is $320.26. Comparing the calculated weighted averages, the actual PMPM is 80.07% of the target PMPM.

For DY10, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $426.27. The actual PMPM weighted for the reporting period using the actual member months and the MMA specific actual PMPM as provided in Table E is $346.26. Comparing the calculated weighted averages, the actual PMPM is 81.23% of the target PMPM.

For DY11, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $446.85. The actual PMPM weighted for the reporting period using the actual member months and the MMA specific actual PMPM as provided in Table E is $376.27. Comparing the calculated weighted averages, the actual PMPM is 84.21% of the target PMPM.

For DY12, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $403.60. The actual PMPM weighted for the reporting period using the actual member months and the MMA specific actual PMPM as provided in Table G is $382.64. Comparing the calculated weighted averages, the actual PMPM is 94.81% of the target PMPM.

For DY13, the weighted target PMPM for the reporting period using the actual member months and the MMA specific targets in the STCs (Table E) is $427.51. The actual PMPM weighted for the reporting period using the actual member months and the MMA specific actual PMPM as provided in Table G is $389.84. Comparing the calculated weighted averages, the actual PMPM is 91.19% of the target PMPM.

Table F shows the Hypothetical & Supplemental Budget Neutrality Test for **MEDS-AD (MEG 4)** established in the MMA Waiver as specified in STC #95. Expenditures cap cost for each DY is calculated by multiplying actual MEDS-AD member months to DY/PMPM and compared to actual waiver expenditures using date of service tracking and reporting.

TABLE F
Hypothetical & Supplemental Budget Neutrality Test for MEDS-AD (MEG 4)

MEDS AD	DY12	DY13	DY14	DY15	DY16	TOTAL
PMPM	$1,004.22	$1,004.22	$1,004.22	$1,004.22	$1,004.22	
Actual MM	595,021	899,412				
Cap Cost	$597,531,989	$903,207,519				$1,500,739,507
Total spend	$360,056,121	$586,220,480				$ 946,276,601
Hypothetical Variance	$237,475,868	$316,987,039				$ 554,462,906

The AIDS Program (MEG 5), The Healthy Start Program (MEG 6), and the **Program for All-inclusive Care for Children (PACC) (MEG 7)** are authorized as Cost Not Otherwise Matchable (CNOM) services under the 1115 MMA Waiver. Table G identifies the DY13 costs for these three programs. For budget neutrality purposes, these CNOM costs are deducted from the savings resulting from the difference between the With Waiver costs and the With-Out Waiver costs identified for DY13 in Table E above.

Table G WW/WOW Difference Less CNOM Costs				
DY13 Difference July 2018 - June 2019:				**$(1,309,919,406)**
CNOM Costs July 2018 – June 2019:				
	AIDS			**$25,989,293**
	Healthy Start			**$21,921,631**
	PACC			**$201,072**
DY13 Net Difference:				**($1,261,807,410)**

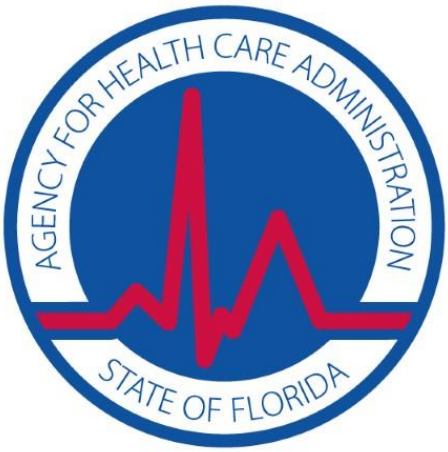
TABLE H MEG 3 Statistics: Low Income Pool	
MEG 3 LIP	**Paid Amount**
DY09/Q34	$690,421,416
DY09/Q35	$556,474,290
DY09/Q36	$830,244,034
DY10/Q37	$0
DY10/Q38	$303,368,192
DY10/Q39	$437,678,858
DY10/Q40	$257,014,028
DY11/Q41	$0
DY11/Q42	$0
DY11/Q43	$390,048,771
DY11/Q44	$187,263,611
DY12/Q45	$0
DY12/Q46	$0
DY12/Q47	$135,591,685
DY12/Q48	$729,468,270
DY13/Q49	$ 16,240,436
DY13/Q50	$0
DY13/Q51	$466,328,947
DY13/Q52	$136,874,270
Total Paid[5]	**$13,115,687,552**

Expenditures for DY13 for **MEG 3**, Low Income Pool (LIP), were $619,443,653 (41.07%) of $1,508,385,773.

Table I MEG 3 Total Expenditures: Low Income Pool			
DY*	**Total Paid**	**DY Limit**	**% of DY Limit**
DY09	$2,077,139,740	$2,167,718,341	95.82%
DY10	$998,061,078	$1,000,000,000	99.81%
DY11	$577,312,382	$607,825,452	94.98%
DY12	$865,059,955	$1,508,385,773	57.35%
DY13	$619,443,653	$1,508,385,773	41.07%

* STC #63 a. The TC dollar limit for LIP expenditures in each DY will be $1,508,385,773.

[5] MMA MEG3 Total (from DY01 on)



Attachments

Attachment I	Statewide Medicaid Managed Care Expanded Benefits
Attachment II	MMA Enrollment Report
Attachment III	Healthy Behaviors Program Enrollment Statistics
Attachment IV	Comprehensive Quality Strategy
Attachment V	Annual Technical Report
Attachment VI	2019 Performance Measure Validation Findings Report
Attachment VII	1115 Demonstration Evaluation Design

Attachment I
Statewide Medicaid Managed Care Expanded Benefits

Expanded Benefits Offered by Health Plans The plans may choose to offer these benefits in addition to State Plan services. Plans are not required to offer all of the expanded benefits.	
General Expanded Benefits *Available for children and/or adults*	Adult Expanded Benefits (cont.)
Cellular Services (minutes and/or data)	Mental Health Targeted Case Management
Circumcision (newborns only)	Nutritional Counseling
CVS Discount Program (20% discount off certain items)	Occupational Therapy
Doula Services (birth coach who helps pregnant women)	Outpatient Hospital Services
Home Delivered Meals	Pet Therapy
Housing Assistance (rent, utilities, and/or grocery assistance)	Physical Therapy
Meal Stipend (available for long distance medical appointment day-trips)	Prenatal Services
Over-the-Counter Benefit	Primary Care Services
Swimming Lessons (children only)	Respiratory Therapy
Transportation Services to Non-Medical Appointments/Activities	Speech Therapy
Adult Expanded Benefits *These services are only available for adults because they are already covered for children on Medicaid when medically necessary*	Substance Abuse Treatment or Detoxification Services (Outpatient)
Acupuncture Services	Therapeutic Behavioral On-Site Services
Art Therapy	Vaccine - Influenza
Behavioral Health Assessment/Evaluation Services	Vaccine - Pneumonia
Behavioral Health Day Services/Day Treatment	Vaccine - Shingles
Behavioral Health Intensive Outpatient Treatment	Vaccine - TDaP
Behavioral Health Medical Services (e.g., medication management, drug screening, etc.)	Vision Services
Behavioral Health Psychosocial Rehabilitation	Waived Copayments
Behavioral Health Screening Services	Long-Term Care Services - *these services are only available for LTC enrollees*
Chiropractic Services	Assisted Living Facility/Adult Family Care Home - Bed Hold Days
Computerized Cognitive Behavioral Therapy	Individual Therapy Sessions for Caregivers

Adult Expanded Benefits (cont.)	Adult Expanded Benefits (cont.)
Durable Medical Equipment/Supplies	Nursing Facility to Community Setting Transition Assistance
Equine Therapy	Child Welfare Specialty Plan Services - *these services are only available for enrollees in a specialty plan*
Group Therapy (Behavioral Health)	Care Grant
Hearing Services	Life Skills Development
Home Health Nursing/Aide Services	Transition Assistance - Youth Aging Out of Foster Care
Homemaker Services (e.g., hypoallergenic carpet cleanings)	HIV/AIDS Specialty Plan Services - *these services are only available for enrollees in a specialty plan*
Home Visit by a Social Worker	Home and Community-Based Services
Individual/Family Therapy	Vaccine - Hepatitis B
Massage Therapy	Vaccine - Human Papilloma Virus
Medication Assisted Treatment Services	Vaccine - Meningococcal

In addition, all dental plans offer these expanded dental benefits if recipients are 21 or older with prior approval from the dental plan:

- ✓ Additional dental exams
- ✓ Additional dental X-rays
- ✓ Additional extractions
- ✓ Dental Screenings
- ✓ Fillings (silver and white)
- ✓ Fluoride
- ✓ Oral Health Instructions
- ✓ Sealants
- ✓ Teeth Cleanings (basic and deep)

Attachment II
Managed Medical Assistance Enrollment Report

There are two categories of Florida Medicaid recipients who are enrolled in an MMA plan: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the MMA enrollment reports, based on the enrollee's eligibility for Medicare. The MMA enrollment reports are a complete look at the entire enrollment for the MMA Waiver for the reporting period. Table 1 provides a description of each column in the MMA enrollment reports that are located on the following pages in Tables 2 and 3.

Table 1
MMA Enrollment by Plan and Type Report Descriptions

Column Name	Column Description
Plan Name	The name of the MMA plan
Plan Type	The plan's type (Standard or Specialty)
Number of TANF Enrolled	The number of TANF recipients enrolled with the plan
Number of SSI Enrolled - No Medicare	The number of SSI recipients enrolled with the plan and who have no additional Medicare coverage
Number of SSI Enrolled - Medicare Part B	The number of SSI recipients enrolled with the plan and who have additional Medicare Part B coverage
Number of SSI Enrolled - Medicare Parts A and B	The number of SSI recipients enrolled with the plan and who have additional Medicare Parts A and B coverage
Total Number Enrolled	The total number of recipients with the plan; TANF and SSI combined
Market Share for MMA	The percentage of the Managed Medical Assistance population compared to the entire enrollment for the year being reported
Enrolled in Previous Year	The total number of recipients (TANF and SSI) who were enrolled in the plan during the previous reporting year
Percent Change from Previous Year	The change in percentage of the plan's enrollment from the previous reporting year to the current reporting year

Table 2 lists the total number of TANF and SSI individuals enrolled, and the corresponding market share, for the reporting period and prior year.

Table 3 lists enrollment by region and plan type, and the total number of TANF and SSI individuals enrolled and the corresponding market share, for the reporting period and prior year.

Table 2
MMA Enrollment by Plan and Type[6]
(July 1, 2018 – June 30, 2019)

Plan Name	Plan Type	Number of TANF Enrolled	Number of SSI Enrolled			Total Number Enrolled	Market Share for MMA by Plan	Enrolled in Previous year	Percent Change from Previous Year
			Medicaid Only	Medicare Part B	Medicare Parts A and B				
Amerigroup Florida	STANDARD	30,624	1,548	10	1,944	**34,126**	0.9%	386,718	-91.2%
Better Health	STANDARD	8,597	428	21	720	**9,766**	0.3%	121,603	-92.0%
Coventry Health Care of Florida	STANDARD	89,841	9,128	74	7,411	**106,454**	2.8%	66,236	60.7%
Florida Community Care	STANDARD	2	791	3	4,993	**5,789**	0.2%	N/A	100.0%
Humana Medical Plan	STANDARD	422,887	53,381	296	49,046	**525,610**	14.1%	389,822	34.8%
Lighthouse Health Plan	STANDARD	28,528	2,371	4	774	**31,677**	0.8%	N/A	100.0%
Miami Children's Health Plan	STANDARD	14,545	1,276	18	516	**16,355**	0.4%	N/A	100.0%
Molina Healthcare of Florida	STANDARD	135,303	14,166	121	10,211	**159,801**	4.3%	444,271	-64.0%
Prestige Health Choice	STANDARD	127,781	9,907	50	6,014	**143,752**	3.8%	419,238	-65.7%
South Florida Community Care Network	STANDARD	43,827	4,085	30	1,857	**49,799**	1.3%	55,006	-9.5%
Simply Healthcare	STANDARD	445,213	52,682	433	26,319	**524,647**	14.0%	93,568	460.7%
Staywell Health Plan	STANDARD	808,009	88,265	183	32,752	**929,209**	24.9%	791,937	17.3%
Sunshine State Health Plan	STANDARD	531,150	48,381	182	62,271	**641,984**	17.2%	615,348	4.3%
United Healthcare of Florida	STANDARD	254,708	29,800	122	25,016	**309,646**	8.3%	340,435	-9.0%
Vivida Health	STANDARD	8,671	731	3	378	**9,783**	0.3%	N/A	100.0%
Standard Plans Total		**2,949,686**	**316,940**	**1,550**	**230,222**	**3,498,398**	**93.6%**	**3,724,182**	**-6.1%**
Positive Health Plan	SPECIALTY	46	81	-	88	**215**	0.1%	**2,395**	-91.0%
Magellan Complete Care	SPECIALTY	22,445	11,118	16	7,487	**41,066**	2.7%	**105,255**	-61.0%
Freedom Health	SPECIALTY	-	-	-	30	**30**	0.0%	**156**	-80.8%
Clear Health Alliance	SPECIALTY	2,580	5,684	11	3,677	**11,952**	0.3%	**11,197**	6.7%
Wellcare of Florida/Staywell	SPECIALTY	45,730	27,207	46	11,459	**84,442**	2.3%	**N/A**	100.0%
Sunshine State Health Plan	SPECIALTY	34,792	1,969	-	5	**36,766**	0.9%	**36,759**	0.0%
Children's Medical Services Network	SPECIALTY	36,019	26,980	-	167	**63,166**	1.5%	**59,069**	6.9%
Specialty Plans Total		**141,612**	**73,039**	**73**	**22,913**	**237,637**	**6.4%**	**214,831**	**10.6%**
MMA TOTAL		**3,091,298**	**389,979**	**1,623**	**253,135**	**3,736,035**	**100%**	**3,939,013**	**-5.2%**

[6] During the year, an enrollee is counted only once in the plan of earliest enrollment. Please refer to http://ahca.myflorida.com/Medicaid/Finance/data_analytics/enrollment_report/index.shtml for actual monthly enrollment totals.

Table 3 MMA Enrollment by Region and Type (July 1, 2018 – June 30, 2019)									
			Number of SSI Enrolled						
Region	Plan Type	Number of TANF Enrolled	No Medicare	Medicare Part B	Medicare Parts A and B	Total Number Enrolled	Market Share for MMA by Region	Enrolled in previous year	Percent Change from previous year
01	Standard & Specialty	108,657	13,808	14	8,277	130,756	3.5%	137,149	-4.7%
02	Standard & Specialty	111,394	16,456	13	9,712	137,575	3.7%	144,210	-4.6%
03	Standard & Specialty	268,532	37,120	43	20,737	326,432	8.7%	332,329	-1.8%
04	Standard & Specialty	331,186	38,469	50	21,273	390,978	10.5%	401,782	-2.7%
05	Standard & Specialty	182,388	25,989	61	20,443	228,881	6.1%	237,248	-3.5%
06	Standard & Specialty	443,860	54,461	136	28,423	526,880	14.1%	541,652	-2.7%
07	Standard & Specialty	427,533	52,823	99	24,760	505,215	13.5%	530,324	-4.7%
08	Standard & Specialty	213,147	21,557	49	17,541	252,294	6.8%	266,699	-5.4%
09	Standard & Specialty	279,635	28,739	147	21,163	329,684	8.8%	354,494	-7.0%
10	Standard & Specialty	265,803	30,904	199	20,805	317,711	8.5%	344,958	-7.9%
11	Standard & Specialty	459,163	69,653	812	60,001	589,629	15.8%	648,168	-9.0%
MMA TOTAL		3,091,298	389,979	1,623	253,135	3,736,035	100%	3,939,013	-5.2%
01	STANDARD	103,865	11,442	14	7,649	122,970	3.5%	134,246	-8.4%
02	STANDARD	104,082	12,616	11	8,681	125,390	3.6%	133,458	-6.0%
03	STANDARD	253,751	29,478	39	18,935	302,203	8.6%	322,002	-6.1%
04	STANDARD	314,867	31,950	48	19,267	366,132	10.5%	377,296	-3.0%
05	STANDARD	171,799	21,049	56	18,366	211,270	6.0%	218,396	-3.3%
06	STANDARD	423,527	44,408	128	25,813	493,876	14.1%	509,785	-3.1%
07	STANDARD	408,331	42,395	93	22,082	472,901	13.5%	500,327	-5.5%
08	STANDARD	203,396	17,169	42	16,211	236,818	6.8%	259,953	-8.9%
09	STANDARD	267,400	23,159	140	19,279	309,978	8.9%	333,857	-7.2%

Table 3 MMA Enrollment by Region and Type (July 1, 2018 – June 30, 2019)									
10	STANDARD	254,666	24,580	192	18,972	298,410	8.5%	322,826	-7.6%
11	STANDARD	444,002	58,694	787	54,967	558,450	16.0%	612,036	-8.8%
STANDARD TOTAL		2,949,686	316,940	1,550	230,222	3,498,398	100.0%	3,724,182	-6.1%
01	SPECIALTY	4,792	2,366	-	628	7,786	3.3%	2,903	168.2%
02	SPECIALTY	7,312	3,840	2	1,031	12,185	5.1%	10,752	13.3%
03	SPECIALTY	14,781	7,642	4	1,802	24,229	10.2%	10,327	134.6%
04	SPECIALTY	16,319	6,519	2	2,006	24,846	10.5%	24,486	1.5%
05	SPECIALTY	10,589	4,940	5	2,077	17,611	7.4%	18,852	-6.6%
06	SPECIALTY	20,333	10,053	8	2,610	33,004	13.9%	31,867	3.6%
07	SPECIALTY	19,202	10,428	6	2,678	32,314	13.6%	29,997	7.7%
08	SPECIALTY	9,751	4,388	7	1,330	15,476	6.5%	6,746	129.4%
09	SPECIALTY	12,235	5,580	7	1,884	19,706	8.3%	20,637	-4.5%
10	SPECIALTY	11,137	6,324	7	1,833	19,301	8.1%	22,132	-12.8%
11	SPECIALTY	15,161	10,959	25	5,034	31,179	13.1%	36,132	-13.7%
SPECIALTY TOTAL		141,612	73,039	73	22,913	237,637	100.0%	214,831	10.6%

Effective December 1, 2018, the Prepaid Dental Health Program (PDHP) is providing Florida State Plan Medicaid dental to all Florida Medicaid recipients in accordance with STC #56.

Table 4 lists the total number of individuals enrolled, and the corresponding market share, for the initial reporting period.

TABLE 4

SMMC DENTAL ENROLLMENT BY PLAN

(JULY 1, 2018 – JUNE 30, 2019

Plan Name	Total Number Enrolled	Market Share for PDHP by Plan	Enrolled in previous year	Percent Change from Previous Year
Managed Care of North America (MCNA)	648,676	18.4%	N/A	0.0%
DentaQuest of Florida	1,715,292	48.8%	N/A	0.0%
Liberty Dental Plan of Florida	1,153,809	32.8%	N/A	0.0%
TOTAL	**3,517,777**	**100.0%**	**N/A**	**0.0%**

Attachment III
Healthy Behaviors Program Enrollment Statistics

Table A provides a summary of enrollees participating in healthy behaviors programs for the reporting period, and **Table B** provides a summary of enrollees who have completed a healthy behaviors program during the reporting period.

For DY13, some MMA plans reported enrollment for only Q1-Q2 or Q3-Q4. This was due to the overlap in reporting from the previous SMMC plans and the current SMMC plans. The tables herein include data from both contracts.

Table A
Healthy Behaviors Program
Enrollment Statistics
(July 1, 2018 - June 30, 2019)

Program	Total Enrolled	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Aetna							
Medically Approved Smoking Cessation Program	7	7	0	0	1	4	2
Medically Directed Weight Loss Program	9	4	5	1	1	7	0
Medically Approved Alcohol or Substance Abuse Recovery Program	8	5	3	2	1	3	2
Prenatal and Post-Partum	328	0	328	7	307	14	0
Amerigroup (Q1-Q2)							
Medically Approved Smoking Cessation Program	16	6	10	0	3	10	3
Medically Directed Weight Loss Program	44	5	39	3	19	17	5
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternal Child Care Services	4,701	0	4,701	755	3,879	67	0
Annual Dental Visit	11,406	5,620	5,786	11,406	0	0	0
Childhood Immunizations	8,568	4,369	4,199	8,568	0	0	0
HEAC	239	93	146	40	79	88	32
Adolescent Immunizations	2,382	1,178	1204	2,382	0	0	0
Performance Measures	0	0	0	0	0	0	0
Comprehensive Diabetes	0	0	0	0	0	0	0

Better Health (Q1-Q2)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	1	0	1	0	0	1	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternity	0	0	0	0	0	0	0
Well Child Visits	30	16	14	30	0	0	0
Children's Medical Services							
Medically Approved Smoking Cessation Program	7	6	1	7	0	0	0
Medically Directed Weight Loss Program	268	130	138	268	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	15	10	5	15	0	0	0
Clear Health Alliance (Q1-Q2)							
Medically Approved Smoking Cessation Program	4	3	1	0	1	1	2
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternity Healthy Behaviors Rewards	0	0	0	0	0	0	0
Well Child Visit Healthy Behaviors Rewards	0	0	0	0	0	0	0
Freedom Health (Q1-Q2)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Florida Community Care (Q3-Q4)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0

Humana Medical Plan							
Medically Approved Smoking Cessation Program	41	14	27	0	20	12	9
Medically Directed Weight Loss Program	11	2	9	1	0	9	1
Medically Approved Alcohol or Substance Abuse Recovery Program	49	14	35	1	23	21	4
Mom's First Prenatal and Postpartum	3,789	0	3,789	375	3,319	95	0
Pediatric Well Visit	5,960	3,050	2,910	5,960	0	0	0
Baby Well Visit	4,462	2,285	2,177	4,462	0	0	0
Telephonic HRA (Q3-Q4)	7,894	2,389	5,505	1,506	2,744	1,999	1,645
Lighthouse (Q3-Q4)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Magellan Complete Care							
Medically Approved Smoking Cessation Program	20	5	15	0	12	8	0
Medically Directed Weight Loss Program	117	18	99	10	60	43	4
Medically Approved Alcohol or Substance Abuse Recovery Program	8	2	6	1	4	3	0
Maternity Incentive Program	267	0	267	67	197	3	0
Access to Preventive/Ambulatory Health Services Program	0	0	0	0	0	0	0
Molina							
Medically Approved Smoking Cessation Program	4	2	2	0	0	4	0
Medically Directed Weight Loss Program	2	0	2	0	1	1	0
Medically Approved Alcohol or Substance Abuse Recovery Program	10	3	7	0	2	7	1
Pregnancy Rewards (Prenatal and Postpartum)	245	0	245	14	226	5	0
Preventive Health	113	59	54	86	24	2	0
Well Child Visits	0	0	0	0	0	0	0

Positive Health Care (Q1-Q2)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	1	1	0	0	0	1	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Childhood Checkups	62	39	23	46	16	0	0
Retinal Eye Exam Program	31	15	16	0	1	28	2
Cervical Cancer Screening Program	5	0	5	0	0	5	0
Prestige Health Choice							
Medically Approved Smoking Cessation Program	3	2	1	0	0	2	1
Medically Directed Weight Loss Program	4	1	3	0	2	2	0
Medically Approved Alcohol or Substance Abuse Recovery Program	2	2	0	0	0	2	0
Behavioral Health Follow-Up Program	1	0	1	0	1	0	0
Diabetes Testing Program	22	6	16	0	3	12	7
Diabetes Eye Exam Program	22	7	15	0	2	13	7
Maternity Program	20	0	20	1	18	1	0
Postpartum Program	2	0	2	0	2	0	0
Well-Child (31 days to 15 months old) Program	1	1	0	1	0	0	0
Well-Child (3 to 6 years old) Program	24	13	11	24	0	0	0
Adolescent Well-Care Program	28	18	10	28	0	0	0
Dental Program (Q1 -Q2)	112	60	52	112	0	0	0
Breast Cancer Screening Program	10	0	10	0	0	5	5
Lead Screening Program	0	0	0	0	0	0	0
Cervical Cancer Screening Program	9	0	9	0	5	2	2
Access to Preventive/Ambulatory Health Services Program (Q3-Q4)	0	0	0	0	0	0	0

Simply							
Medically Approved Smoking Cessation Program	1	0	1	0	0	0	1
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternal Child Services: Maternal	141	0	141	14	124	3	0
Maternal Child Services: Child (Q3-Q4)	28	7	8	28	0	0	0
Well Child Visits	15	9	6	15	0	0	0
Asthma Management (Q3-Q4)	0	0	0	0	0	0	0
SFCCN - Community Care Plan							
Medically Approved Smoking Cessation Program	1	1	0	0	1	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	12	5	7	2	8	2	0
Pregnancy- Completed prenatal and postpartum exam	34	0	34	2	29	3	0
Well child 15 months - 6 visits	106	52	54	106	0	0	0
Annual Well Child Exam ages 2-11	2,776	1,395	1,381	2,774	0	0	0
Annual Well Child Exam ages 12-19	1,356	702	654	1,356	0	0	0
Annual Well Adult Exam ages >= 20	260	59	201	20	135	83	22
Diabetes Screening (A1c, Microalbumin and Eye exam)	184	76	108	2	16	92	74
Staywell							
Medically Approved Smoking Cessation Program:	73,784	25,002	48,782	4,775	31,466	26,342	11,201
Medically Directed Weight Loss Program:	34,603	15,002	19,601	22,271	6,592	4,290	1,450
Alcohol or Substance Abuse Recovery Program:	3,595	1561	2,034	687	1,435	1,185	288
New Member Healthy Behaviors: Health Risk Assessment (Q1-Q2, Q4)	175,602	73,111	102,491	103,011	41,857	18,392	12,342
New Member Healthy Behaviors: Initial PCP Visit (Q1-Q2)	87,744	37,329	50,415	50,429	20,266	10,037	7,012

Staywell (Cont.)							
Children's Healthy Behaviors: Well Child Visit	35,863	18,509	17,354	35,863	0	0	0
Children's Healthy Behaviors: Child Health Check Up	120,033	61,890	58,143	120,033	0	0	0
Children's Healthy Behaviors: Adolescents Check Up	314,420	157,568	156,852	310,099	4,060	0	0
Children's Healthy Behaviors: Dental Check Up (Q1-Q2)	4,773	2,361	2,412	4,687	80	0	0
Children's Healthy Behaviors: Lead Screening (Q1-Q2)	4,022	2,097	1,925	4,022	0	0	0
Well Woman Healthy Behaviors: Screening Mammogram	42,516	0	42,516	0	2,675	33,715	6,126
Well Woman Healthy Behaviors: Cervical Screening (Q3-Q4)	204,223	0	204,223	0	129,792	64,274	10,157
Well Woman Healthy Behaviors: Chlamydia Screening (Q3-Q4)	73,143	0	73,143	54,219	18,924	0	0
Diabetes Healthy Behaviors: Eye Exam	15,114	5,295	9,819	257	2,853	8,200	3,804
Diabetes Healthy Behaviors: HgbA1C Control	15,034	9,404	5,630	256	2,831	8,156	3,791
Diabetes Healthy Behaviors: Blood Pressure Control (Q3-Q4)	14,897	5,217	9,680	255	2,799	8,097	3,746
Prenatal Visits	16,424	0	16,315	2,571	13,626	227	0
Postpartum Visits	10,734	0	10,734	5,670	4,991	73	0
MMA Backpack Project	225,055	114,903	110,152	225,055	0	0	0
Adult Health Healthy Behaviors: Annual Wellness Visit (Q3-Q4)	181,510	58,366	123,144	1,263	99,987	52,589	27,671
Teen Pregnancy Prevention Program (Q1-Q2)	0	0	0	0	0	0	0
Sunshine Health							
Medically Approved Smoking Cessation Program	51	23	28	0	9	27	15
Medically Directed Weight Loss Program	155	40	115	37	33	64	21
Medically Approved Alcohol or Substance Abuse Recovery Program	8	4	4	0	1	6	1

United Healthcare							
Medically Approved Smoking Cessation Program	63	25	38	1	19	29	14
Medically Directed Weight Loss Program	76	16	60	1	18	43	14
Medically Approved Alcohol or Substance Abuse Recovery Program	4	3	1	0	1	2	1
Baby Blocks	1,821	0	1,821	212	1,584	25	0
Vivida Health (Q3-Q4)							
Medically Approved Smoking Cessation Program	4	1	3	1	0	3	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	4	3	1	1	1	2	0

Table B Healthy Behaviors Program Completion Statistics (July 1, 2018 - June 30, 2019)							
Program	Total Completed	Gender		Age (years)			
		Male	Female	0–20	21–40	41–60	Over 60
Aetna							
Medically Approved Smoking Cessation Program	3	3	0	0	0	3	0
Medically Directed Weight Loss Program	1	0	1	0	0	1	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Prenatal and Post-Partum	223	0	223	5	207	11	0
Amerigroup (Q1-Q2)							
Medically Approved Smoking Cessation Program	2	1	1	0	0	1	1
Medically Directed Weight Loss Program	5	1	4	0	0	3	2
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternal Child Care Services	501	96	405	201	298	2	0
Annual Dental Visit	7	4	3	7	0	0	0
Childhood Immunizations	288	141	147	288	0	0	0
HEAC	5	4	1	0	1	3	1
Adolescent Immunizations	489	238	251	489	0	0	0
Performance Measures	0	0	0	0	0	0	0
Comprehensive Diabetes	5	4	1	0	1	3	1
Better Health (Q1-Q2)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternity	0	0	0	0	0	0	0
Well Child Visits	11	5	6	10	0	0	0

Children's Medical Services							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	5	3	2	5	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Clear Health Alliance (Q1-Q2)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternity Healthy Behaviors Rewards	0	0	0	0	0	0	0
Well Child Visit Healthy Behaviors Rewards	0	0	0	0	0	0	0
Freedom Health (Q1-Q2)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Florida Community Care (Q3-Q4)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0

Humana Medical Plan							
Medically Approved Smoking Cessation Program	9	4	5	0	1	7	1
Medically Directed Weight Loss Program	4	0	4	0	0	3	1
Medically Approved Alcohol or Substance Abuse Recovery Program	3	1	2	0	1	2	0
Mom's First Prenatal and Postpartum	725	0	725	64	635	26	0
Pediatric Well Visit	5,849	2,960	2,889	5,849	0	0	0
Baby Well Visit	2,361	1,168	1,193	2,361	0	0	0
Telephonic HRA (Q3-Q4)	4,983	1,479	3,504	758	1,657	1,288	1,280
Lighthouse (Q3-Q4)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Magellan Complete Care							
Medically Approved Smoking Cessation Program	1	0	1	0	0	0	1
Medically Directed Weight Loss Program	1	0	1	0	1	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	1	0	1	1	0	0	0
Maternity Incentive Program	40	0	40	6	34	0	0
Access to Preventive/Ambulatory Health Services Program	0	0	0	0	0	0	0
Molina							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Pregnancy Rewards (Prenatal and Postpartum)	76	0	76	5	70	1	0
Preventive Health	7	3	4	5	2	0	0
Well Child Visits	0	0	0	0	0	0	0

Positive Health Care (Q1-Q2)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Childhood Checkups	12	11	1	9	3	0	0
Retinal Eye Exam Program	31	15	16	0	1	28	2
Cervical Cancer Screening Program	5	0	5	0	0	5	0
Prestige Health Choice							
Medically Approved Smoking Cessation Program	2	2	0	0	0	2	0
Medically Directed Weight Loss Program	1	0	1	0	0	1	0
Medically Approved Alcohol or Substance Abuse Recovery Program	2	2	0	0	0	2	0
Behavioral Health Follow-Up Program	1	0	1	0	1	0	0
Diabetes Testing Program	22	6	16	0	3	12	7
Diabetes Eye Exam Program	22	7	15	0	2	13	7
Maternity Program	20	0	20	1	18	1	0
Postpartum Program	2	0	2	0	2	0	0
Well-Child (31 days to 15 months old) Program	1	1	0	1	0	0	0
Well-Child (3 to 6 years old) Program	24	13	11	24	0	0	0
Adolescent Well-Care Program	29	19	10	29	0	0	0
Dental Program (Q1 -Q2)	112	60	52	112	0	0	0
Breast Cancer Screening Program	10	0	10	0	0	5	5
Lead Screening Program	0	0	0	0	0	0	0
Cervical Cancer Screening Program	10	0	10	0	6	2	2
Access to Preventive/Ambulatory Health Services Program (Q3-Q4)	0	0	0	0	0	0	0

Simply							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Maternal Child Services: Maternal	13	4	9	9	4	0	0
Maternal Child Services: Child (Q3-Q4)	22	0	0	22	0	0	0
Well Child Visits	8	3	5	8	0	0	0
Asthma Management (Q3-Q4)	0	0	0	0	0	0	0
SFCCN - Community Care Plan							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	11	4	7	2	6	3	0
Pregnancy- Completed prenatal and postpartum exam	34	0	34	2	29	3	0
Well child 15 months - 6 visits	106	52	54	106	0	0	0
Annual Well Child Exam ages 2-11	2,776	1,395	1,381	2,774	0	0	0
Annual Well Child Exam ages 12-19	1,356	702	654	1,356	0	0	0
Annual Well Adult Exam ages >= 20	260	59	201	20	135	83	22
Diabetes Screening (A1c, Microalbumin and Eye exam)	184	76	108	2	16	92	74

Staywell							
Medically Approved Smoking Cessation Program:	75	7	68	2	51	19	3
Medically Directed Weight Loss Program:	44	15	29	24	15	5	0
Alcohol or Substance Abuse Recovery Program:	6	1	5	0	3	3	0
New Member Healthy Behaviors: Health Risk Assessment (Q1-Q2, Q4)	329	127	202	172	89	55	13
New Member Healthy Behaviors: Initial PCP Visit (Q1-Q2)	405	145	260	258	92	42	13
Children's Healthy Behaviors: Well Child Visit	95	56	39	95	0	0	0
Children's Healthy Behaviors: Child Health Check Up	341	184	157	339	2	0	0
Children's Healthy Behaviors: Adolescents Check Up	361	181	186	349	12	0	0
Children's Healthy Behaviors: Dental Check Up (Q1-Q2)	252	119	133	252	0	0	0
Children's Healthy Behaviors: Lead Screening (Q1-Q2)	36	19	17	36	0	0	0
Well Woman Healthy Behaviors: Screening Mammogram	78	0	78	0	0	56	22
Well Woman Healthy Behaviors: Cervical Screening (Q3-Q4)	203	0	203	0	141	57	5
Well Woman Healthy Behaviors: Chlamydia Screening (Q3-Q4)	42	0	42	12	30	0	0
Diabetes Healthy Behaviors: Eye Exam	154	30	124	2	49	75	28
Diabetes Healthy Behaviors: HgbA1C Control	244	45	199	3	71	120	50
Diabetes Healthy Behaviors: Blood Pressure Control (Q3-Q4)	245	47	198	4	77	117	47
Prenatal Visits	935	0	935	47	877	11	0
Postpartum Visits	510	0	510	30	474	6	0

Staywell (Cont.)							
MMA Backpack Project	93	49	44	93	0	0	0
Adult Health Healthy Behaviors: Annual Wellness Visit (Q3-Q4)	388	42	346	4	243	121	20
Teen Pregnancy Prevention Program (Q1-Q2)	0	0	0	0	0	0	0
Sunshine Health							
Medically Approved Smoking Cessation Program	4	0	4	0	0	3	1
Medically Directed Weight Loss Program	50	17	33	4	12	25	9
Medically Approved Alcohol or Substance Abuse Recovery Program	2	1	1	0	1	0	1
United Healthcare							
Medically Approved Smoking Cessation Program	6	4	2	0	0	2	4
Medically Directed Weight Loss Program	4	2	2	0	1	3	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0
Baby Blocks	668	0	668	77	581	10	0
Vivida Health (Q3-Q4)							
Medically Approved Smoking Cessation Program	0	0	0	0	0	0	0
Medically Directed Weight Loss Program	0	0	0	0	0	0	0
Medically Approved Alcohol or Substance Abuse Recovery Program	0	0	0	0	0	0	0

Attachment IV

Florida's Comprehensive Quality Strategy

2017

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APPENDIX 1

Managed Care Contract Provisions

List of Tables

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 Strategy[1]:

- 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 withinone 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**
GOALS:				
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**
CURRENT INITIATIVES SUPPORTING GOALS				
• 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	• Medicaid Physician Incentive Program (MPIP) • Single Preferred Drug List (PDL) • Early Elective Deliveries (EED) Policy • Long-Acting Reversible Contraceptives Initiatives (LARCs) • Performance Improvement Projects: - Prenatal Care - Well Child Visits in First 15 Months • Healthy Start Services Re-Design for Managed Medical Assistance (MMA) • Family Planning Waiver	• 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	• 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)	• Clinical Quality Monitoring • Recipient and Provider Assistance • Complaint Hub • Quality PIP Teams • Physical and Behavioral Health Integration • Statewide 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 HEDIS[3] 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 measures[5] (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) surveys[6]; and
- Long-term Care Plan Enrollee Survey[7].

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 Cards[8], which are available to Medicaid enrollees for use in selecting a plan. The current consumer report cards include audited[9] HEDIS performance measure results. CAHPS survey results are also posted online for consumers to view[10]. 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.

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[6] CAHPS 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 requirements[11], 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 MPIPs 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 payments[14]. 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_physicial_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, validated[20] Performance Improvement Plans (PIPs) are 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 Coalitions[21] 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 Heathy 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

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[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:

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[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.]

(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 children[29] 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 Childrens' 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 – Total[1]	47%
PDENT[2]	33%
TDENT[3]	15%
SEA[4]	13%

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

[2]PDENT 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.

[3]TDENT 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.

[4]SEA 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 consulted[31], 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 isrecognizable 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

- 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 - 07-08-2

Florida Medicaid Oral Health Social M

Social Media Measurement:

FacebookTracking.docx

TwitterTracking.docx

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.

Table 1
External Quality Review
42 CFR 438 Subpart E

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VII, A.1.b.
Prepaid Inpatient Health Plans	
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.

Table 2
Delivery Network Requirements
42 CFR 438.206(b)(1)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VI, A.
Prepaid Inpatient Health Plans	
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.

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

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

Table 5
Outside the Network
42 CFR 438.206(b)(4)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Care Program	Attachment II, Exhibit A, Section V, A.1.a.
Prepaid Inpatient Health Plans	
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.

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

Table 7
Provider Credentialing
42 CFR 438.206(b)(6)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VI, C.2.a. (4)
Prepaid Inpatient Health Plans	
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.

Table 8
Timely Access to Care
42 CFR 438.206(c)(1)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VI, , C.6.c.(6) and A.4
Prepaid Inpatient Health Plans	
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.

Table 9
Cultural Considerations
42 CFR 438.206(c)(2)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section IV, B.4.a.
Prepaid Inpatient Health Plans	
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.

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

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VI, A.1.
Prepaid Inpatient Health Plans	
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.

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

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

(b) *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.

Table 13
Coordination of Services
42 CFR 438.208(b)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section V. E.2.b
Prepaid Inpatient Health Plans	
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.

Table 14
Duplicative Services for Individuals with Special Health Care Needs
42 CFR 438.208(b)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section V. D.3.a.
Prepaid Inpatient Health Plans	
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.

Table 15
Privacy Protection
42 CFR 438224 and 42 CFR 431 subpart F

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section V, E.2.a.(7) and Section I, A
Prepaid Inpatient Health Plans	
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.

Table 16
Additional Services for Individuals with Special Health Care Needs
42 CFR 438.208(c)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b; Exhibit A, Section V, E.2.b and E.4.c.(8)(11)
Prepaid Inpatient Health Plans	
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.

Table 17
Coverage of Services
42 CFR 438.210(a)(1)(2)(3)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section II, D. 12 and 18; Section V, A.1, a-d
Prepaid Inpatient Health Plans	
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.

Table 18
Medically Necessary Services
42 CFR 438.210(a)(4)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section I and Section II, D.13
Prepaid Inpatient Health Plans	
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.

Table 19
Service Authorization Policies & Procedures.
42 CFR 438.210(b)(d)(1)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section II, D.20; Section IV, A.7.b.(8); Section VII, G.2.e-h
Prepaid Inpatient Health Plans	
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.

Table 20
Appropriate Health Care Professional / Denial of Services
42 CFR 438.210(b)(3)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VII, G.4.a
Prepaid Inpatient Health Plans	
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.

Table 21
Identification of Persons with Special Health Care Needs
42 CFR 438.208(c)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b; Section II, D.18; Exhibit A, Section V, E.4.c
Prepaid Inpatient Health Plans	
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.

Table 22
Treatment Plan Standard
42 CFR 438.208(c)(3)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Exhibit A, Section V, E.4.c.(8)
Prepaid Inpatient Health Plans	
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.

Table 23
Provider Selection and Retention, Credentialing and Recredentialing, Nondiscrimination, and Excluded Providers
42 CFR 438.12(a)(2), 42 CFR 438.214(a)-(d), 42 CFR 438.206(b)(6)

Plan Type	Contract Provision
Managed Care Organizations	
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)
Prepaid Inpatient Health Plans	
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 4704of the Balanced Budget Act of 1997);
- A detailed description of the plan's process used to determine whether health careservices 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.

Table 24
Enrollee Information
Section 1932(b)(3), of Social Security Act and 42 CFR 438.10(f)

Plan Type	Contract Provision
Managed Care Organizations	
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.
Prepaid Inpatient Health Plans	
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.

Table 25
Confidentiality
45 CFR parts 160 and 164, 42 CFR 438.224

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section V, E.2.a.(7)
Prepaid Inpatient Health Plans	
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 ofthe 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 responsiblefor 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 warningof 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.

Table 26
Enrollment & Disenrollment
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
Managed Care Organizations	
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).
Prepaid Inpatient Health Plans	
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:

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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:

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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.

Table 27 *Grievance System* 42 CFR 431.200 and 438, Subpart F	
Plan Type	**Contract Provision**
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section I, A; Section IV, C; Section VII, G.6.a.
Prepaid Inpatient Health Plans	
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 abilityto 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 andregulations.
- The plans' contracts require that if the plan identifies deficiencies or areas forimprovement, 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.

Table 28
Subcontracted Relationships & Delegation
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
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VIII, B.1-3.
Prepaid Inpatient Health Plans	
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.

Table 29
Practice Guidelines
42 CFR 438.236(b)(c)(d)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VII, G.3.a.b.c.
Prepaid Inpatient Health Plans	
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;
- Preventive 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 recredentialing, 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.

Table 31
Performance Improvement Projects
42 CFR 438.240(b)(1)(b)(2)(c)(d)(1)(2)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VII, A.1.b and d; A.6.
Prepaid Inpatient Health Plans	
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 1st.

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 (15th) 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 (20th) 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 (4th) 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.

Table 34
Assessment of the Quality & Appropriateness of Care and Services
42 CFR 438.208(c)(2)(3)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b., E.4.c.
Prepaid Inpatient Health Plans	
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.

Table 35
Identification and Assessment of Individuals with Special Health Care Needs
42 CFR 438.208(c)(2)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VI, B.2.b.; Attachment II, Exhibit A, Section V, E.2.b.
Prepaid Inpatient Health Plans	
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.

Table 36
Monitoring and Evaluation
42 CFR 438.240(d)(2)

Plan Type	Contract Provision
Managed Care Organizations	
Managed Medical Assistance Program	Attachment II, Section VII, A.5.d.4.(b).
Prepaid Inpatient Health Plans	
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 < 25th percentile - immediate monetary sanction and PMAP may be imposed Rate < 50th 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 50th 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 50th 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.

Table 5
Required MMA Performance Measures 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	Comprehensive Diabetes Care (CDC) • 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 - ≥ 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 (≥ 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.

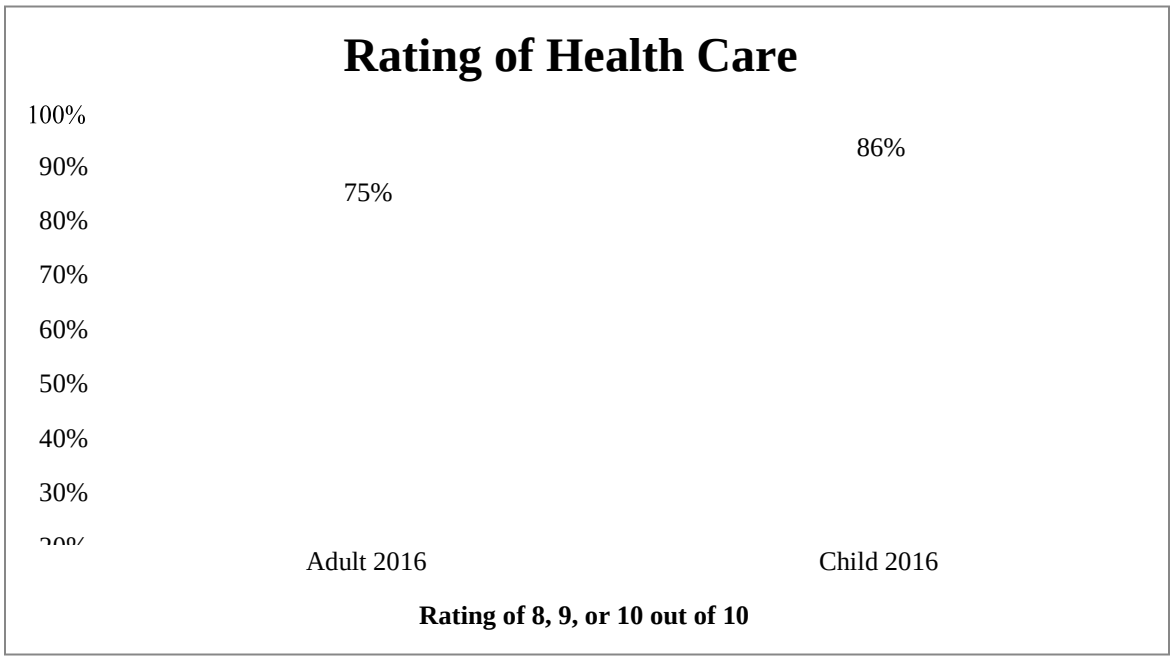
Plans are required to report their certified results to the Agency on an annual basis. Beginning with the 2016 survey, plans were also required to report their results to NCQA so they may be included in the National Medicaid Means and Percentiles. The results of these surveys are posted on the Agency's 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.

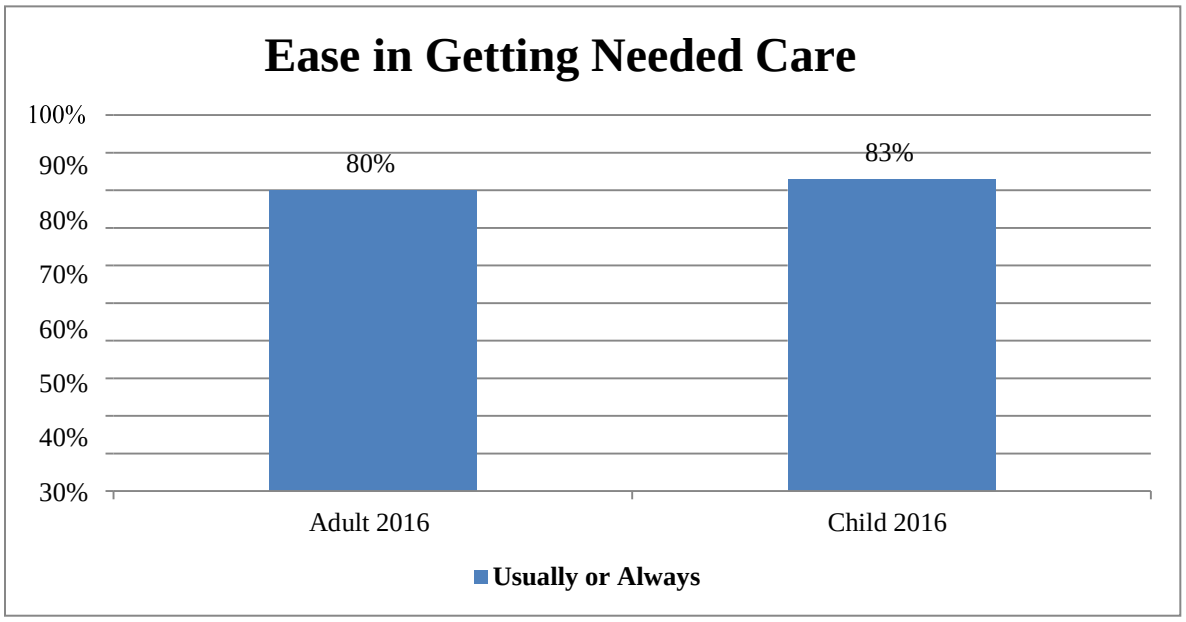
Rating of Health Care

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.



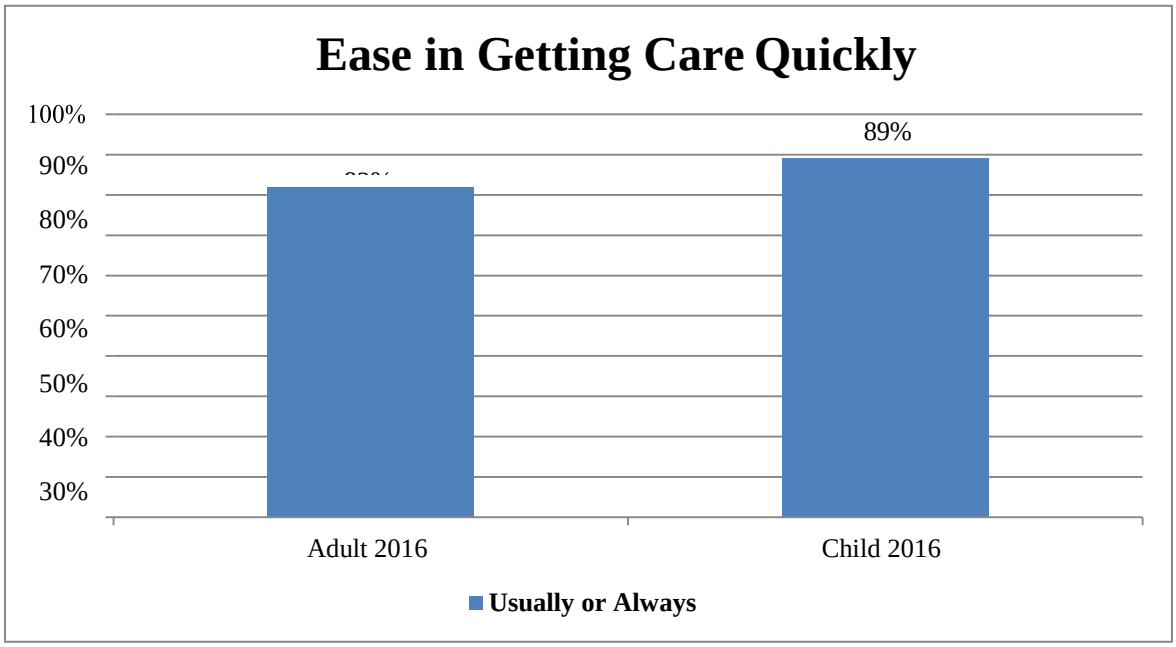
Getting Needed Care and Getting Care Quickly

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.



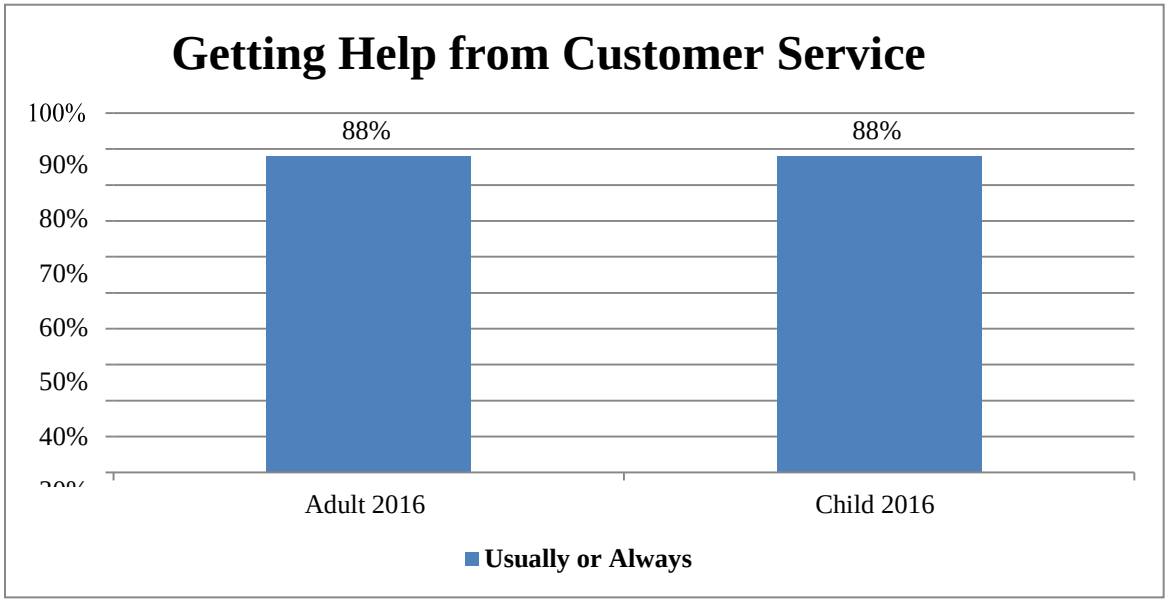
Getting Care Quickly

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: • 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 Rate 5.0 or lower – PMAP may be required
Satisfaction with Care Manager	
Rating of Quality of Services	

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	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. If the Managed Care Plan's rate remains below the 25th percentile in subsequent years, damages will be $1,000 per case.

Required Record Documentation - numerators 1-4	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. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be $1,000 per case.
Face-to-Face Encounters	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. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be $1,000 per case.
Care Manager Training	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. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be $1,000 per case.
Timeliness of Service	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. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be $1,000 per case.
Satisfaction with Care Manager and LTC Managed Care Plan	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. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be $1,000 per case.
Rating of Quality of Services	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. If the Managed Care Plan's rate remains below 90% in subsequent years, damages will be $1,000 per case.

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.

Table 13
2016 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**
>= 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

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 (≥ 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**
HEDIS Measures	
Care for Older Adults	90th percentile
Call Answer Timeliness	90th percentile
Agency-Defined	
Required Record Documentation • 701B Assessment • Freedom of Choice Form • Plan of Care/Enrollee Participation • Plan of Care/PCP Notification	 95% 95% 95% 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

Attachment V
2017-2018 Annual Technical Report

Florida Agency for Health Care Administration

SFY 2017–2018 External Quality Review Technical Report

May 2019

Table of Contents

Glossary of Acronyms

AAAHC ..... Accreditation Association for Ambulatory Health Care
AAP ..... *Adults' Access to Preventive/Ambulatory Health Services*
ABA ..... *Adult BMI Assessment*
ADD ..... *Follow-Up Care for Children Prescribed ADHD Medication*
ADHD ..... Attention-deficit/Hyperactivity Disorder
ADV ..... *Annual Dental Visit*
AHCA ..... Florida Agency for Health Care Administration
AHRQ ..... Agency for Healthcare Research and Quality
AIDS ..... Acquired Immunodeficiency Syndrome
ALF ..... Assisted Living Facility
AMM ..... *Antidepressant Medication Management*
AOD ..... *Alcohol and Other Drug*
APC ..... *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*
APM ..... *Metabolic Monitoring for Children and Adolescents on Antipsychotics*
APP ..... *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*
AWC ..... *Adolescent Well-Care Visits*
BAA ..... Business Associate Agreement
BBA ..... Balanced Budget Act of 1997
BCS ..... *Breast Cancer Screening*
BMI ..... Body Mass Index
BR ..... *Biased Rate*
CAB ..... *Call Abandonment*
CAHPS ..... Consumer Assessment of Healthcare Providers and Systems
CAP ..... Corrective Action Plan
CAP ..... *Children and Adolescents' Access to Primary Care Practitioners*
CAT ..... *Call Answer Timeliness*
CBP ..... *Controlling High Blood Pressure*
CCP ..... Cultural Competency Program
CCP-AD ..... *Contraceptive Care—Postpartum Women—Ages 21–44 Years*
CCP-CH ..... *Contraceptive Care—Postpartum Women—Ages 15–20 Years*
CCS ..... *Cervical Cancer Screening*
CDC ..... *Comprehensive Diabetes Care*
CEU ..... Continuing Education Unit
CFA ..... *Care for Adults*
CFR ..... Code of Federal Regulations
CHCUP ..... Child Health Check-Up
CHIP ..... Children's Health Insurance Program
CHL ..... *Chlamydia Screening in Women*

CIS ..... *Childhood Immunization Status*
CMS ..... Centers for Medicare & Medicaid Services
CMT ..... *Case Manager Training*
COC ..... Continuity of Care
COA ..... *Care for Older Adults*
CQS ..... Comprehensive Quality Strategy
CY ..... Calendar Year
DOEA ..... Department of Elder Affairs
DSS ..... Decision Support System
ED ..... Emergency Department
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
ER ..... Emergency Room
F2F ..... *Face-to-Face Encounters*
FAR ..... Final Audit Report
FFS ..... Fee-for-Service
FFY ..... Federal Fiscal Year
FHM ..... *Follow-Up After Hospitalization for Mental Illness*
FMMIS ..... Florida's Medicaid Management Information System
F.S. ..... Florida Statutes
FUA ..... *Follow-Up After ED Visit for AOD Abuse or Dependence*
FUM ..... *Follow-Up After Emergency Department (ED) Visit for Mental Illness*
HbA1c ..... Hemoglobin A1c
HCBS ..... Home and Community-Based Services
HCFA ..... Health Care Financing Administration
HEDIS ..... Healthcare Effectiveness Data and Information Set
HIPAA ..... Health Insurance Portability and Accountability Act of 1996
HIV ..... Human Immunodeficiency Virus
HMO ..... Health Maintenance Organization
HSAG ..... Health Services Advisory Group, Inc.
ICD ..... International Classification of Diseases
IET ..... *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
IMA ..... *Immunizations for Adolescents*
IS ..... Information Systems
ITN ..... Invitation to Negotiate
LDL-C ..... Low-density Lipoprotein Cholesterol
LDs ..... Liquidated Damages
LO ..... Licensed Organization
LSC ..... *Lead Screening in Children*
LTC ..... Long-Term Care
LTSS ..... Long-Term Services and Supports

MCO ..... Managed Care Organization
MCST ..... Managed Care Survey Tool
Medicaid Quality ..... Bureau of Medicaid Quality
MediPass ..... Medicaid Provider Access System
MMA ..... Managed Medical Assistance
MMA ..... *Medication Management for People With Asthma*
MPM ..... *Annual Monitoring for Patients on Persistent Medications*
MRRV ..... Medical Record Review Validation
MSC ..... *Medical Assistance With Smoking and Tobacco Use Cessation*
NAS ..... Neonatal Abstinence Syndrome
NCQA ..... National Committee for Quality Assurance
NICU ..... Neonatal Intensive Care Unit
NPI ..... National Provider Identifier
NR ..... *Not Reported*
OB/GYN ..... Obstetrician/Gynecologist
PAHP ..... Prepaid Ambulatory Health Plan
PCCM ..... Primary Care Case Management
PCP ..... Primary Care Practitioner
PCR-AD ..... *Plan All-Cause Readmissions*
PDF ..... Portable Document Format
PDO ..... Participant Direction Option
PDSA ..... Plan-Do-Study-Act
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PMO ..... Bureau of Plan Management Operations
PMV ..... Performance Measure Validation
PNOU ..... Provider Network Oversight Unit
PNV ..... Provider Network Verification
PPC ..... *Prenatal and Postpartum Care*
PSN ..... Provider Service Network
QI ..... Quality Improvement
RER ..... *Mental Health Readmission Rate*
Roadmap ..... Record of Administration, Date Management, and Processes
RRD ..... *Required Record Documentation*
RY ..... Reporting Year
SAA ..... *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
SEAL ..... *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk*
SFY ..... State Fiscal Year
SI ..... Study Indicator
SIPP ..... Statewide Inpatient Psychiatric Program
SMI ..... Serious Mental Illness

SMMC ..... Statewide Medicaid Managed Care
SSD ..... *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
TA ..... Technical Assistance
Td ..... Tetanus-Diphtheria
Tdap ..... Tetanus-Diphtheria-Pertussis
TOS ..... *Timeliness of Services*
UOD ..... *Use of Opioids at High Dosage*
UOP ..... *Use of Opioids From Multiple Providers*
VL ..... Viral Load
VLS ..... *Viral Load Suppression Among Persons in HIV Medical Care*
W15 ..... *Well-Child Visits in the First 15 Months of Life*
W34 ..... *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC ..... *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
WIC ..... Women, Infants, and Children

1. Executive Summary

Overview of the External Quality Review

The Code of Federal Regulations (CFR) at 42 CFR §438.364[1-1] requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes the manner in which data from activities conducted for Medicaid managed care organizations (MCOs), in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that MCOs provide. The state fiscal year (SFY) 2017–2018 External Quality Review Technical Report of Results, prepared for the Florida Agency for Health Care Administration (AHCA), is presented to comply with 42 CFR §438.364. Health Services Advisory Group, Inc. (HSAG), is the EQRO for AHCA, the State agency responsible for the overall administration of Florida's Medicaid managed care program.

This is the 12th year HSAG has produced the external quality review (EQR) report for the State of Florida. The information presented in this report does not disclose the identity of any individual, in accordance with 42 CFR §438.364(d). The purpose of the SFY 2017–2018 External Quality Review Technical Report is to comply with the requirements as set forth under 42 CFR part 438 Managed Care Rules, which require states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.352 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality of, timeliness of, and access to care furnished by the contracted plans. This includes assessing the degree to which the plans addressed recommendations made in the previous year.

HSAG's external quality review of the MCOs included directly performing two of the three federally mandated activities as set forth in 42 CFR §438.358—validation of performance improvement projects (PIPs) and validation of performance measures. The third mandatory activity—evaluation of compliance with federal managed care standards—must be conducted once in a three-year period.

Summary of Findings, Conclusions, and Recommendations

Performance Improvement Projects (PIPs)

During SFY 2017–2018, the MMA plans submitted four PIPs for validation, including the following topics: two state-mandated topics, one additional nonclinical topic, and one additional clinical topic. For the additional clinical topic, the MMA plans were required to select a topic falling into one of three categories: a population health issue within a specific geographic area identified as in need of improvement (such as diabetes, hypertension, or asthma); integration of primary care and behavioral health; or reduction of preventable readmissions. The LTC plans submitted two PIPs for validation,

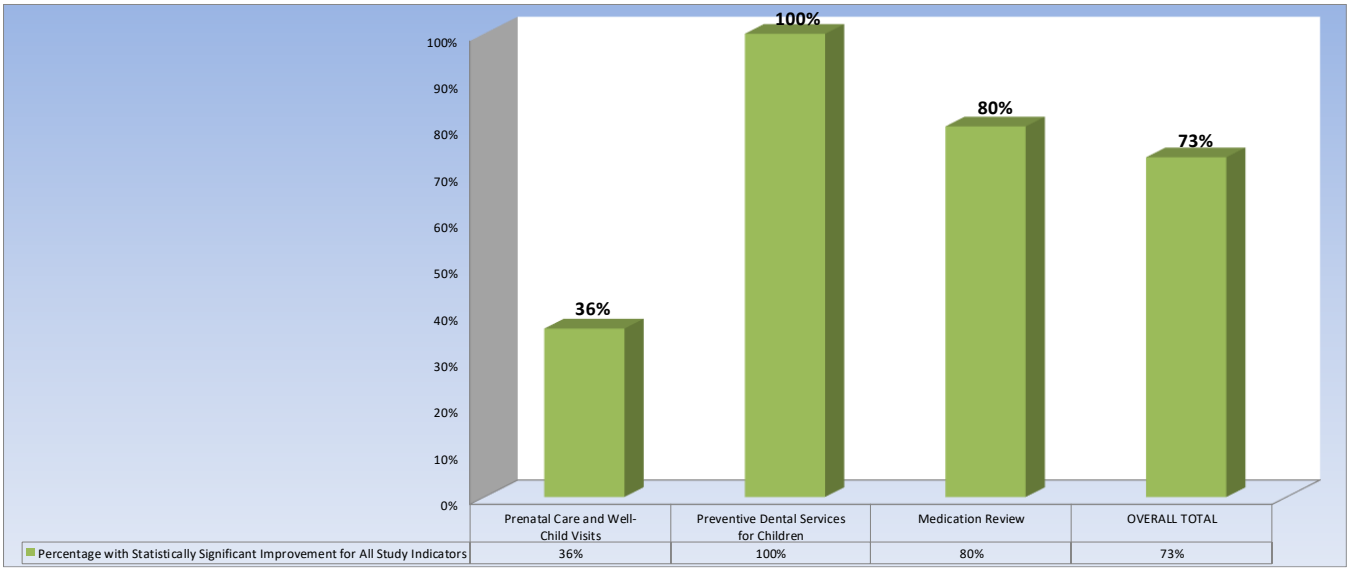
[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27886. 42 CFR Parts 364 Medicaid Program; External Quality Review, Final Rule.

including the following topics: one state-mandated topic and one nonclinical topic. Comprehensive plans that offered services for both the MMA and LTC programs submitted six PIPs for validation, adhering to the PIP topic requirements for both programs. For some of the specialty plans, exceptions were made to the mandated PIP topics when the topic did not apply to the population served.

Statistically Significant Improvement

For the SFY 2017–2018 validation cycle, the plans reported Remeasurement 1 and Remeasurement 2 study indicator results, and the PIPs were evaluated for achieving real improvement from baseline to the most recent remeasurement period. The percentages of state-mandated PIPs that demonstrated statistically significant improvement over baseline across all study indicators are presented in Figure 1-1.

Figure 1-1—Percentage of SFY 2017–2018 State-Mandated PIPs That Achieved Statistically Significant Improvement Over Baseline for All Study Indicators, by PIP Topic

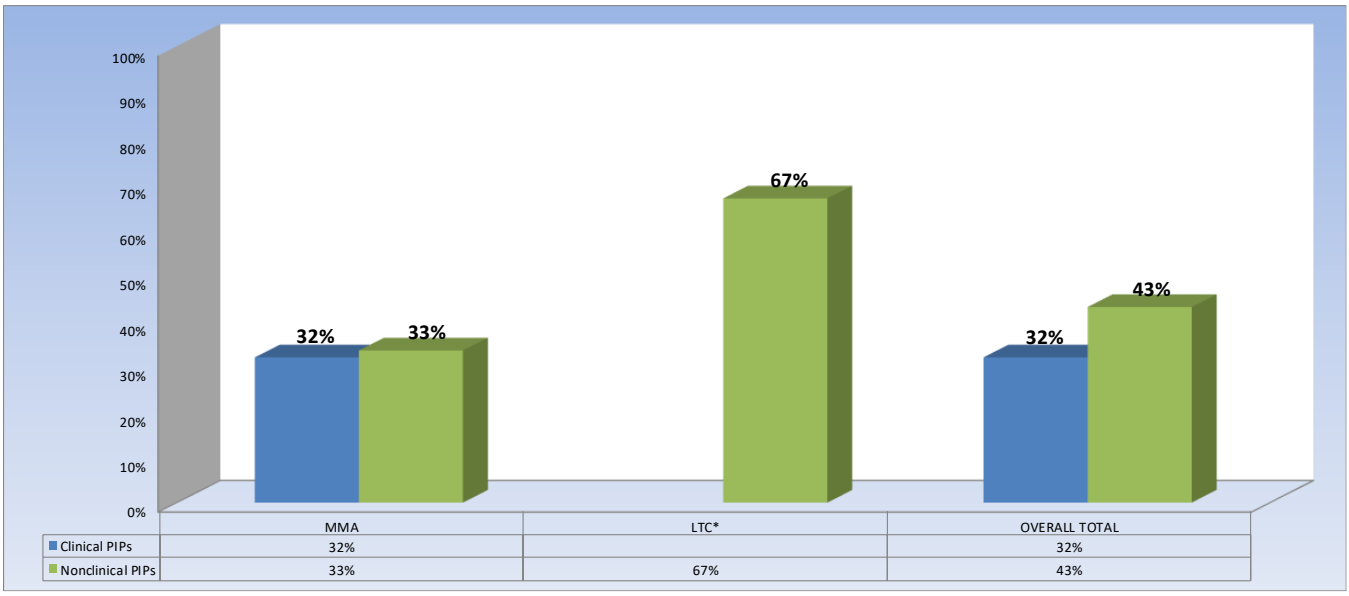


Across the three state-mandated topics, 73 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. The percentage of PIPs demonstrating statistically significant improvement across all study indicators varied by state-mandated topic: 36 percent of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs, 100 percent of the *Preventive Dental Services for Children* PIPs, and 80 percent of the *Medication Review* PIPs.

For this year's validation, PIPs that demonstrated statistically significant improvement across all study indicators last year at Remeasurement 1 and had comparable Remeasurement 2 results reported for this year's validation were assessed for sustained improvement in study indicator outcomes. Among the state-mandated PIPs, HSAG evaluated 17 PIPs (three *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs and all 14 *Preventive Dental Services for Children* PIPs) for sustained improvement, and all 17 PIPs were successful in maintaining the significant improvement over baseline across all study indicators for a second re-measurement.

In addition to the state-mandated PIPs represented in Figure 1-1, HSAG evaluated the plan-selected clinical and nonclinical PIPs for achieving real improvement across all study indicators. The percentages of plan-selected clinical and nonclinical PIPs that demonstrated statistically significant improvement over baseline across all study indicators are presented in Figure 1-2.

Figure 1-2—Percentage of SFY 2017–2018 Plan-Selected Clinical and Nonclinical PIPs That Achieved Statistically Significant Improvement Over Baseline for All Study Indicators, by PIP Topic and Plan Type



* The LTC plans did not submit any plan-selected clinical PIPs for validation; therefore, no data are displayed for LTC clinical PIPs.

Thirty-two percent of the clinical PIPs with comparable remeasurement results demonstrated statistically significant improvement over baseline across all study indicators. These results are based on the clinical PIPs conducted by the MMA plans because AHCA did not require the LTC plans to submit plan-selected clinical PIPs for validation during SFY 2017–2018. Among all nonclinical PIPs with comparable remeasurement results, 43 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. A greater percentage of nonclinical PIPs conducted by the LTC plans (67 percent) than conducted by the MMA plans (33 percent) demonstrated statistically significant improvement over baseline across all indicators. For additional information related to study indicators demonstrating statistically significant improvement, see Section 6—Performance Improvement Projects.

For this year's validation, HSAG also assessed for sustained improvement those plan-selected PIPs that demonstrated statistically significant improvement across all study indicators at Remeasurement 1 and had comparable Remeasurement 2 results reported this year. A pattern like the state-mandated PIPs was seen for the nonclinical plan-selected PIPs in that all four PIPs evaluated for sustained improvement successfully maintained significant improvement across all study indicators for the second remeasurement. The plan-selected clinical PIPs were the only PIPs that did not have a 100 percent success rate in sustained improvement for this year's validation; only one of four clinical PIPs evaluated

for sustained improvement was successful at maintaining statistically significant improvement for a second remeasurement period.

Innovative Interventions Associated With Statistically Significant Improvement

As part of the PIP validation process, HSAG identifies innovative interventions employed in PIPs that achieved statistically significant improvement across all study indicators. During the SFY 2017–2018 validation cycle, HSAG identified innovative interventions associated with statistically significant improvement for each of the three state-mandated PIP topics, *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Preventive Dental Visits for Children*, and *Medication Review*. HSAG also identified innovative interventions in three plan-selected clinical PIP topics (*Annual Diabetic Retinal Eye Exam*, *Behavioral Health Screening of CHA [Clear Health Alliance] Members by a PCP [Primary Care Practitioner]* and *Plan All-Cause Readmissions [PCR]*) and one plan-selected nonclinical topic (*Timeliness of Services*). Examples of the innovative interventions include new or redesigned processes for onboarding enrollees and connecting them with services, facilitating partnerships between primary care and dental providers to increase access to preventive dental services, and use of peer support specialists to assist enrollees in pre-discharge planning and scheduling of needed follow-up care after hospitalization. A full description of the innovative interventions identified during the SFY 2017–2018 validation cycle can be found in Section 6—Performance Improvement Projects.

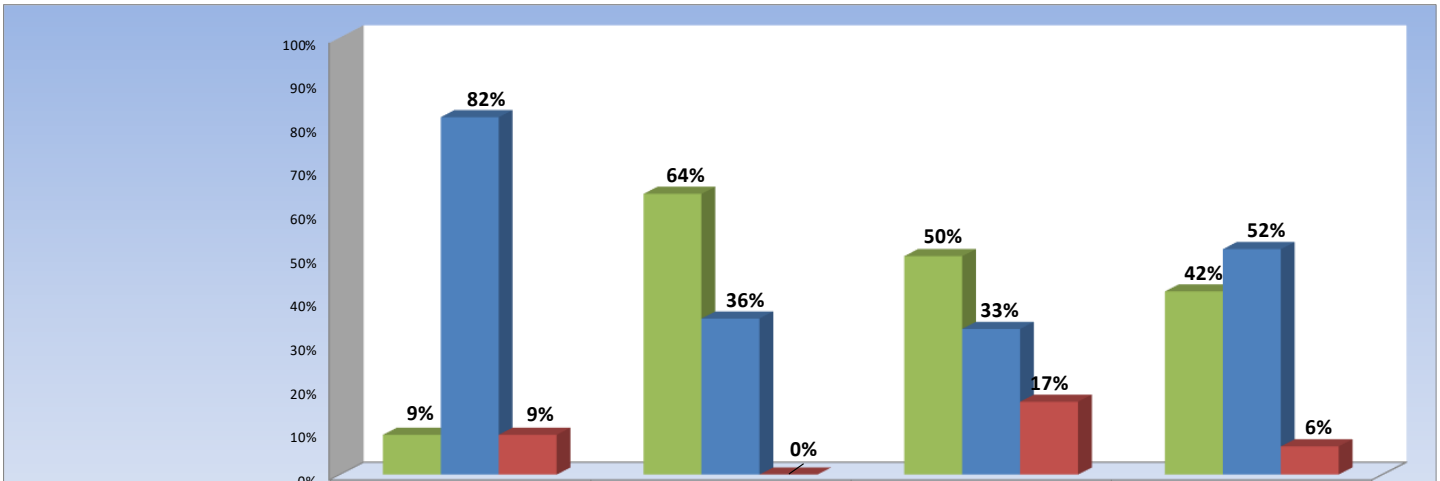
Overall PIP Validation Status

HSAG validated PIPs submitted by all plans as required by the EQRO contract. The outcome of the validation process was an overall validation status finding for each PIP of *Met*, *Partially Met*, or *Not Met*. To determine the overall validation status for each PIP, HSAG evaluated the PIP on a set of standard evaluation elements that aligned with the three PIP stages—Design, Implementation, and Outcomes—and the 10 steps in CMS' *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-2] HSAG designated some evaluation elements as critical because of their importance in defining a project as valid and reliable. Each PIP was evaluated on up to 29 elements, 14 of which are deemed critical and must receive a *Met* score for the PIP to receive a *Met* overall validation status. The PIP also had to receive a *Met* score for 80 percent or more of all applicable evaluation elements to receive a *Met* overall validation status. The details of HSAG's PIP validation process are provided in Section 6—Performance Improvement Projects.

Figure 1-3 displays the percentage of state-mandated PIPs receiving a *Met*, *Partially Met*, and *Not Met* overall validation status by plan type and PIP topic for the SFY 2017–2018 validation cycle. Thirty-one of the 76 PIPs validated focused on one of the three state-mandated topics. The green bars represent the percentage of PIPs with an overall validation status of *Met*, the blue bars represent the percentage of PIPs with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

[1-2] Ibid.

Figure 1-3—Overall Validation Status of State-Mandated PIPs by PIP Topic

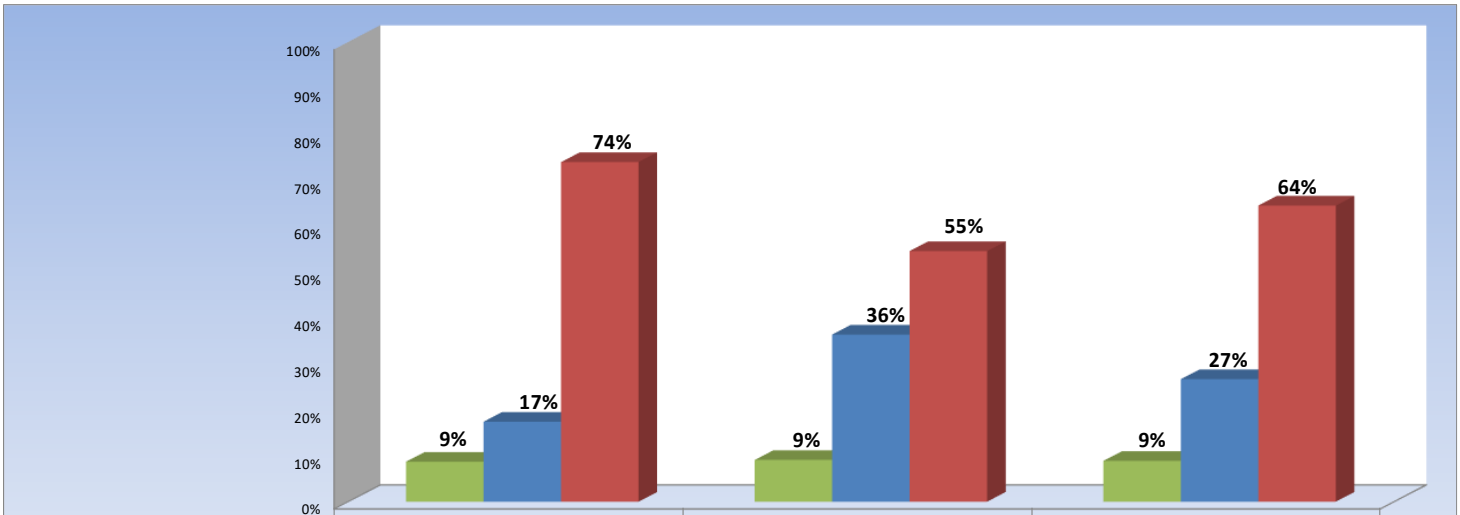


	Prenatal Care and Well-Child Visits	Preventive Dental Services for Children	Medication Review	OVERALL TOTAL
Percentage of PIPs with Met Status	9%	64%	50%	42%
Percentage of PIPs with Partially Met Status	82%	36%	33%	52%
Percentage of PIPs with Not Met Status	9%	0%	17%	6%

Across all state-mandated PIPs, 42 percent received an overall *Met* validation status, 52 percent received an overall *Partially Met* validation status, and 6 percent received a *Not Met* validation status. The percentage of PIPs receiving a *Met* validation status was highest for the *Preventive Dental Services for Children* PIPs (64 percent). The second-highest percentage (50 percent) of PIPs receiving a *Met* validation status was among the *Medication Review* PIPs. The *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs had the lowest percentage, with only 9 percent of the PIPs receiving an overall *Met* validation status. Most of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs (82 percent) received a *Partially Met* validation status, suggesting that the PIPs addressed some but not all critical evaluation elements included in HSAG's PIP validation methodology.

In addition to the 31 state-mandated PIPs represented in Figure 1-1, HSAG validated 23 plan-selected clinical PIPs and 22 plan-selected nonclinical PIPs. Figure 1-4 displays the percentage of clinical and nonclinical PIPs receiving a *Met*, *Partially Met,* and *Not Met* overall validation status for the SFY 2017–2018 validation cycle. The green bars represent the percentage of PIPs with an overall validation status of *Met*, the blue bars represent the percentage of PIPs with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

Figure 1-4—Overall Validation Status of Plan-Selected Clinical and Nonclinical PIPs



	Clinical PIPs	Nonclinical PIPs	OVERALL TOTAL
Percentage of PIPs with Met Status	9%	9%	9%
Percentage of PIPs with Partially Met Status	17%	36%	27%
Percentage of PIPs with Not Met Status	74%	55%	64%

The validation results for the plan-selected PIPs demonstrate that the plans continue to have room for improvement in addressing HSAG's evaluation requirements for receiving a *Met* validation status. An equal percentage of clinical and nonclinical PIPs (9 percent) received a *Met* validation status. A smaller percentage of clinical PIPs (17 percent) than nonclinical PIPs (36 percent) received a *Partially Met* validation status. For both clinical and nonclinical PIPs, the most common validation status was *Not Met*, with 74 percent of clinical PIPs, 55 percent of nonclinical PIPs, and 64 percent of plan-selected PIPs overall receiving a *Not Met* validation status. The results suggest that most of the plan-selected clinical and nonclinical PIPs did not address all HSAG's PIP validation requirements.

Recommendations

Based on the validation results across all PIPs, HSAG made observations about the design and implementation of the PIPs during the baseline measurement period. HSAG offers the following recommendations related to the validation scores to improve the structure and implementation of the PIPs as well as to support progress toward improved PIP outcomes in the future. Further detail on opportunities for improvement and expanded recommendations are provided in Section 6—Performance Improvement Projects.

Overall recommendations:

- AHCA should continue to explore and identify innovative interventions and share intervention examples with the plans. Sharing potentially promising strategies with the plans may help facilitate improvement in individual PIPs and in statewide efforts.

- The plans should conduct accurate data analyses of study indicator results and appropriate statistical testing between each study indicator re-measurement rate and the baseline rate to evaluate PIP progress toward achieving and sustaining statistically significant improvement in study indicator outcomes.
- The plans should use active, innovative improvement strategies that have the potential to directly and positively impact study indicator outcomes for each PIP.
- The plans should have a methodologically robust process in place for evaluating the effectiveness of each intervention and its impact on the study indicators and should use intervention-specific evaluation results to guide next steps of each intervention.

Performance Measure Validation

HSAG conducted performance measure validation (PMV) activities for the measures calculated and reported by MMA Standard plans, MMA Specialty plans, and LTC plans for reporting year (RY) 2018. All measure indicator data were audited by a National Committee for Quality Assurance (NCQA) Licensed Organization (LO) in line with the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] Compliance Audit™[1-4] policies and procedures. HSAG's role in the validation of performance measures was to ensure that audit activities conducted by the LO were consistent with the CMS publication, *Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012 (CMS Performance Measure Validation Protocol).[1-5]

MMA Plans

All MMA Standard plans were required to report 76 measure indicators, which were grouped into six domains (Pediatric Care, Women's Care, Living With Illness, Behavioral Health, Access/Availability of Care, and Use of Services). For the current measurement year, all MMA plans were fully compliant with NCQA HEDIS Compliance Audit Information Systems (IS) standards 2.0, 3.0, 5.0, and 7.0.

A total of 67 MMA Standard plan performance measure indicators related to **quality** were evaluated as part of the Pediatric Care, Women's Care, Living With Illness, Behavioral Health, and Use of Services domains. Of the 33 measure indicators that had an established performance target in this area, eight (24.2 percent) measure indicators met or exceeded the AHCA performance targets. **Additionally, the statewide average met or exceeded the minimum performance targets for 25 of 33 (75.8 percent) measures indicators**.

A total of 24 MMA Standard plan performance measure indicators related to **access** were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, and Access/Availability of Care domains. Of the measures that had an established performance target, two of 15 (13.3 percent) measure indicators met or

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-4] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Feb 12, 2019.

exceeded the AHCA performance targets. **Additionally, the statewide average met or exceeded the minimum performance targets for seven of 15 (46.7 percent) measure indicators.**

A total of 21 MMA Standard plan performance measure indicators related to **timeliness** were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, and Access/Availability of Care domains. Of the measure indicators that had an established performance target in this area, two of five (40.0 percent) measure indicators met or exceeded the AHCA performance targets. **Additionally, the statewide average met or exceeded the minimum performance targets for four of five (80.0 percent) measure indicators.**

Six MMA Specialty plans operated during RY 2018. Some MMA Specialty plans were not required to report performance measures because of the enrollee population that they served. The HIV/AIDS Specialty plans (Clear Health-S and Positive-S) and the Serious Mental Illness (SMI) Specialty plan (Magellan-S) reported no measures beyond the MMA Standard plan performance measures, while the Children's Medical Services Network plan (Children's Medical Services-S) and Child Welfare Specialty plan (Sunshine-S) reported measures related to the child population. The Chronic Disease Specialty plan (Freedom-S) reported measures for the older adult population.

LTC Plans

For RY 2018, the LTC plans were required to report six AHCA-defined measures. The LTC plans were compliant with all NCQA HEDIS Compliance Audit IS standards. HSAG had no concerns with the data systems and processes used by the LTC plans for measure calculations based on the information present in the final audit reports (FARs). The LTC plans continued to have adequate validation processes in place to ensure data completeness and accuracy.

The LTC plans reported 12 performance measure indicator rates, which were all related to **quality** or **timeliness**. For *Call Answer Timeliness*, the only measure for which AHCA established a performance target, the statewide average rate met the AHCA performance target, **demonstrating an area of strength for the LTC plans**.

Recommendations

Overall, 32 statewide MMA plan rates fell below AHCA's performance targets, and nine exceeded the performance targets. While opportunities for improvement exist in almost all domains of care, HSAG recommends that improvement efforts be focused on measures with RY 2018 rates falling below AHCA's performance targets by at least 10 percentage points, such as in the Pediatric Care domain (*Lead Screening in Children, Immunizations for Adolescents—Combination 1,* and *Annual Dental Visit—Total*); Living With Illness (*Medication Management for Patients on Persistent Medications—Medication Compliance 75%—Total*); and Access/Availability of Care (*Adults' Access to Preventive/Ambulatory Health Services—Total*).

For the LTC plans, *Call Answer Timeliness* was the only performance measure that was assigned a performance target by AHCA. The 2018 rate for *Call Answer Timeliness* **exceeded AHCA's performance target** by just under 5 percentage points. Although most statewide average rates improved from RY 2017 to RY 2018, three measures (*Required Record Documentation—Freedom of Choice Form* and *Plan of* Care—*LTC Service Authorizations*; and *Case Manager Training*) demonstrated a decline in performance; therefore, HSAG recommends that LTC plans investigate the root cause of the noncompliance for these measures. Specifically, for *Required Record Documentation—Freedom of Choice Form* and *Plan of* Care—*LTC Service Authorizations*, HSAG recommends that LTC plans ensure proper documentation is maintained for enrollees. For *Case Manager Training*, LTC plans should ensure proper and timely training of their case managers regarding the mandate to report abuse, neglect, and exploitation.

Review of Compliance

On July 14, 2017, AHCA released the re-procurement solicitation of its SMMC health and dental plans. Due to the competitive procurement, AHCA was in a statutorily imposed "blackout period" until 72 hours after the award. The blackout period is in accordance with §287.057(23), F.S. which states[1-6]:

> Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response.

AHCA released the intent to award on June 28, 2018. As a result of this black-out period, compliance monitoring activities were suspended.

During SFY 2017–2018, AHCA began readiness reviews to focus on assessing each managed care plan's readiness and ability to provide services to Florida Medicaid recipients. AHCA created a plan readiness strategy that included (1) development of readiness review tools, (2) procedures for completing a desk review and on-site surveys, (3) review of implementation action plans, (4) processes for document review and approval, and (5) processes for ensuring that provider networks were in place.

AHCA also began strategic planning for how to conduct a comprehensive three-year compliance review according to the federal standards. As a part of planning, AHCA requested a cost estimate from its EQRO, to complete the following tasks related to compliance reviews: (1) development of a compliance review tool to include federal and state contract standards, (2) desk reviews of the evidence of compliance provided by the plans, (3) on-site visits to the plans, including interviews with staff and

[1-6] Florida Legislature. The 2018 Florida Statutes. Available at: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0200-0299/0287/Sections/0287.057.html. Accessed on: Feb 5, 2019.

document review, (4) generating preliminary reports of the results of the compliance review using the compliance review tool, and (5) developing full reports of the results of the compliance review in a report format. AHCA has notified the EQRO that the state is working internally to determine how the EQRO can support the state in planning and executing the mandatory three-year compliance review.

Recommendations

HSAG recommends the following:

- In accordance with 42 CFR §438.358(b)(1)(iii), AHCA should continue working internally to enhance its systematic reviews by conducting a comprehensive compliance review every three years to determine each plan's adherence to all federal standards in subparts D and E. AHCA should also continue to work in partnership with the EQRO for planning and executing the mandatory three-year compliance review.
- The plans should anticipate compliance reviews and maintain a checklist of compliance activities to determine internal issues with their own processes. The plans could use the federal standards as required and conduct internal risk assessments to identify and promptly address any deficiencies. Specifically, the plans should focus efforts on Provider Network, Administration and Management, Reporting, Quality and Utilization Management, and Covered Services standards.

2. Introduction to the Annual Technical Report

Purpose Statement

The purpose of the SFY 2017–2018 External Quality Review Technical Report is to comply with the requirements as set forth under 42 CFR part 438 Managed Care Rules, which require states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.352 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality of, timeliness of, and access to care furnished by the contracted plans. This includes assessing the degree to which the plans addressed recommendations made in the previous year.

Quality, Access, and Timeliness

CMS has identified the domains of quality, access, and timeliness as keys to evaluating MCO performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of these domains.

- **Quality**, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement. [2-1]
- **Access**, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. [2-2]
- **Timeliness** is described by NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2-2] Ibid.
[2-3] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

3. Overview of the Florida Medicaid Managed Care Program

Florida's Medicaid Managed Care Program

In 2011, the Florida legislature created the SMMC program, which has two components: the MMA program and the LTC program. Under the SMMC program, the majority of Medicaid beneficiaries receive their health care services through a managed care plan.

- Seven managed care plans were selected to provide services for the LTC program, which consolidated five home and community-based services (HCBS) programs into a single managed LTC and HCBS waiver. The LTC program was implemented by region, with the first regions enrolling on August 1, 2013, and the final regions enrolling on March 1, 2014.
- Fourteen managed care plans and six Specialty plans were selected to provide services for the MMA program. Plans were phased in from May to August 2014.

The Agency initiated a competitive re-procurement (ITN) of the SMMC contracts on July 14, 2017 (contract term through September 2023). The Agency awarded contracts to plans in each of the 11 regions of the State. Under the new contracts, there are four plan types that may provide services:

- Seven Comprehensive Plans were awarded contracts - this plan type provides services to Medicaid beneficiaries who qualify for both MMA and LTC services and beneficiaries who only qualify for MMA services.
- One Long-term Care Plus Plan was awarded a contract - this plan type provides services only to Medicaid beneficiaries who qualify for both MMA and LTC services.
- Five MMA Plans were awarded contracts - this plan type provides services to Medicaid beneficiaries who only qualify for MMA services.
- Four Specialty Plans were awarded contracts - this plan type only provides MMA services to Medicaid beneficiaries who meet certain specialty criteria.

The Florida Legislature directed AHCA to implement a separate dental managed care component of the SMMC program. On October 16, 2017, AHCA released another ITN to provide services under the SMMC Dental Health Program. All Medicaid beneficiaries (with very limited exceptions) are required to enroll in a dental plan. Like SMMC plans, dental plans have five-year contracts (contract term through September 2023). AHCA selected three dental plans to operate statewide, with each dental plan operating in all 11 regions of the State.

AHCA also has a statewide contract with the Department of Health, Children's Medical Services (DOH/Children's Medical Services), to serve children with chronic conditions through the DOH/Children's Medical Services Specialty plan. This contract is statutorily exempt from the SMMC procurement requirements and requires the Children's Medical Services plan to meet all other health plan requirements for the MMA program.

Implementation of the new SMMC contracts occurred over a three-phased schedule: Phase 1—December 1, 2018; Phase 2—January 1, 2019; and Phase 3—February 1, 2019.

Florida Medicaid Managed Care Demographics

The demographics of the Florida Medicaid population (excluding the FFS population) as of August 2018 were as follows:

- Approximately 2.9 million were enrolled in an MMA Standard plan.
- Approximately 180,000 were enrolled in an MMA Specialty plan.
- Approximately 102,000 were enrolled in an LTC plan.

The State's Comprehensive Quality Strategy

Part of AHCA's mission is to promote better healthcare for all Floridians. AHCA's Comprehensive Quality Strategy (CQS) 2017 documents priorities and goals that guide the design for delivery of Medicaid services in Florida via AHCA, its contracted plans, and their service providers. This strategy also forms an integrated framework to guide improvement of the various elements of service delivery. AHCA's primary focus is to improve health quality while streamlining processes and providing transparency and accountability for all functions. The CQS outlines AHCA'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 SFY 2016–17.

CMS Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their members.

HSAG performed a crosswalk with AHCA's Quality Strategy and the CMS requirements and found that AHCA's Quality Strategy met the requirements of 42 CFR §438.340.

In line with the CMS goals in its quality strategy, AHCA outlined five priorities for Florida Medicaid for SFY 2017–2018. Related to each priority are specific, measurable goals to guide the program's priority quality initiatives. These efforts are designed to measurably improve the health outcomes of enrollees in the most efficient, innovative, and cost-effective ways possible. AHCA strives to provide high-quality care to all enrollees, regardless of their race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location. AHCA considers health disparities in the development and implementation of all QI and initiatives.

The five priorities and the accompanying goals are listed as follows[3-1]:

[3-1] Agency for Health Care Administration. Florida Medicaid Comprehensive Quality Strategy Summary. Available at: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/docs/CQS_Final_Draft_2017_03-02-2017.pdf. Accessed on: Feb 1, 2019.

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

4. Review of Compliance

Background

Section 1932(c) of the Social Security Act requires State Medicaid agencies to provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract.

Title 42 CFR §438.358(b)(1)(iii)[4-1] requires that states complete a review, conducted in the previous three-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D of this part and the quality assessment and performance improvement requirements described in §438.330.

During SFY 2017–2018, AHCA was involved in a re-procurement solicitation of its SMMC health and dental plans, with awards granted to SMMC plans in April 2018. In addition to monitoring activities, AHCA began readiness reviews that focused on assessing the SMMC plans' readiness to provide services to Medicaid recipients. To accomplish the readiness reviews, AHCA developed readiness review tools and procedures for completing a desk review and on-site surveys, reviewed implementation of action plans, developed processes for document review and approval, and developed a process to ensure provider networks were established and adequate for new and existing enrollees.

To meet the CMS requirements in 42 CFR §438.358(b)(1)(iii) for a comprehensive three-year compliance review, AHCA began a strategic planning process to implement the federal requirements. As a first step, AHCA requested a cost estimate from the EQRO to complete the following tasks related to compliance reviews:

- Development of a compliance review tool to include federal and State contract standards
- Desk reviews of the evidence of compliance provided by the plans
- On-site visits to the plans, including interviews with plan staff and an on-site document review
- Generating preliminary reports of the compliance review results using the compliance review tool
- Developing full reports of the results of the compliance review in a report format

Methodology/Technical Methods of Data Collection and Analysis

The following bureaus and offices within AHCA's Division of Medicaid use various methods of review to collect data and monitor plan operations to ensure compliance with all State contract requirements

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

and most of the federally required standards. Listed with each entity is the methodology it used for conducting monitoring and reviews.

Methods of Review by Bureau/Office

Bureau of Plan Management Operations (PMO)

The Bureau of Plan Management Operations (PMO) engages in ongoing monitoring activities through contract management, specialized monitoring units, and coordination with other Medicaid bureaus, AHCA divisions, and external organizations.

Contract management and monitoring is the function of PMO's Comprehensive, Standard, and Specialty Plan Management Sections, which also serve as internal and external contact points for SMMC managed care plans and other AHCA bureaus and divisions.

Through periodic on-site and desk reviews, PMO contract managers ensure their assigned managed care plan meets Medicaid contractual requirements, including the timely provision of medically needed services and provider payment for such services. They address contractually required Access, Measurement and Improvement, and Structure and Operation standards through:

- Tracking and trending complaints from the Medicaid Issues Resolution Center and identified in Medicaid fair hearing requests.
- Reviewing the plan's self-reported systems issues.
- Reviewing weekly encounter reports.
- Reviewing plan subcontracts against the subcontract delegation checklist, which includes applicable CFR language.

PMO contract managers also ensure contractual compliance with enrollee written materials.

The Long-Term Care (LTC) Oversight Unit is housed within the Comprehensive Plan Management Section of PMO. This unit focuses on ensuring SMMC contract compliance with LTC-related requirements of the CFR and the Medicaid and CHIP Managed Care Final Rule. The LTC Unit addresses areas specific to:

- Tracking and trending LTC-related complaints from the Medicaid Issues Resolution Center.
- Reviewing Medicaid Fair Hearing requests related to LTC services.
- Reviewing managed care plan enrollee materials related to LTC for compliance with LTC policy provisions of the contract.

The LTC Oversight Unit reviews compliance action requests from other AHCA functional units and coordinates with PMO contract managers to initiate compliance actions. The LTC Oversight Unit also coordinates with Medicaid Quality on enrollee case file reviews and performance measures, works with AHCA systems on special projects related to LTC, and aids other functional units in understanding LTC requirements.

The Provider Network Oversight Unit (PNOU) is housed within PMO's Standard Plan Management section. PNOU is responsible for the review, monitoring, and maintenance of AHCA-established

standards and requirements for provider networks. PNOU also initiates compliance actions against managed care plans who fail to meet the provider network provisions of the contract. PNOU addresses contractually required Access, and Structure and Operations standards through:

- Reviewing PNV data files.
- Reviewing Quest Ratio reports to identify and track specific provider types for network adequacy against the plan's PDF.
- Analyzing provider online directories.
- Validating terminated and excluded provider information against the plans' PNV files to ensure that excluded providers are not included in the plans' networks.
- Reviewing complaints received by the Medicaid Issues Resolution Center.
- Reviewing PCP Wait Times reports and Annual Network Development plans.
- Performing secret shopper exercises.

The Compliance Coordination Section is responsible for both intra- and inter-Agency coordination of contract compliance and enforcement under the SMMC program, which includes the oversight, development, and enhancement of compliance processes, tools, and templates. This section works with other AHCA bureaus and sections to ensure plans' compliance with contract requirements, including working with managed care plans statewide to address claims management, marketing, and general plan management issues. Additionally, this section is responsible for the review of administrative procedures, guidelines, etc., which impact managed care compliance related to enrollee complaints, grievances, and appeals, along with provider complaints, and conducts in-depth reviews, analysis, and trending to identify compliance issues.

There are two field-based offices within the Bureau of PMO; the Tampa Field Based Plan Management Unit and the Ft. Lauderdale Field Based Plan Management Unit. The Tampa Field Based Plan Management Unit is responsible for working with managed care plans statewide to address marketing and general plan management issues. This involves reviewing administrative policies, procedures, guidelines, and related directives impacting managed care plan contract compliance, evaluating contract compliance through oversight of managed care plan marketing activities, identifying potential program operations and compliance issues and problems, and recommending appropriate action.

The Ft. Lauderdale Field Based Plan Management Unit is responsible for working with managed care plans statewide to address claims management and general plan management issues. This involves reviewing administrative policies, procedures, guidelines, and related directives impacting managed care plan contract compliance; evaluating contract compliance through oversight of managed care plan claim and claim complaint processing; conducting in-depth reviews, analysis, and trending to identify compliance issues/potential program operations problems; and recommending appropriate action.

PMO works in conjunction with the Medicaid Quality to address Grievance System requirements by:

- Reviewing complaints submitted through the Medicaid Issues Resolution Center, Medicaid fair hearing requests, and plans' monthly reports regarding enrollee complaints, grievances, and appeals and denial, reduction, termination, or suspension of services.
- Reviewing and approving plans' notice of action and other grievance and appeal letters to enrollees.

Bureau of Medicaid Quality

The Bureau of Medicaid Quality (Medicaid Quality) monitors specific enrollee-centered priority areas including private duty nursing and targeted monitoring of Statewide Inpatient Psychiatric Program (SIPP) care coordination; therapy services; prenatal, newborn, and postpartum care; potentially preventable hospital and emergency room (ER) visits; and unnecessary ancillary services during hospitalization or ER visits. Medicaid Quality conducts monthly, quarterly, and annual reviews of the Report Guide disease management summary reports; medical case record review strategy summary reports; vaccines for children summary reports; and a clinical review of health policy changes and outreach, education, and clinical initiatives documents.

Medicaid Quality addresses contractually required Measure and Improvement standards by reviewing plans' PIPs, performance measure results, provider and enrollee survey results, and QI plans.

HIPAA Compliance Office

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance Office receives and reviews reports and notifications identified in the business associate agreement (BAA). These reports are reviewed for timeliness, completeness, and accuracy. If a deficiency is identified, a corrected form may be requested or a compliance action request may be sent to the contract manager for any final action. If no deficiencies are present, the contract manager would be notified.

The HIPAA Compliance Office receives the notifications to the Department of Health and Human Services identified in the standard contract as well as in Item 10d of the BAA from the contract managers for an annual review. These notifications are compared to the reports submitted under the BAA throughout the year for discrepancies, including identification of any breaches not reported to AHCA. If a deficiency is identified, a compliance action request would be sent to the contract manager for any final action.

The HIPAA Compliance Office receives complaints submitted by any party related to these BAAs as well as any additional self-reported issues. A review of these complaints and reports is conducted and reviewed for any appropriate recommendations to the contract managers based on the requirements of the contracts and/or the BAA.

Review of Compliance Actions

PMO contract managers review the compliance actions issued throughout the year, as well as complaints received and other types of escalations. As mentioned, most methods of review did not result in an escalation for a compliance action of any kind, so they were noted as *Met*. AHCA considers a standard *Met* if results from most of the methods of review comply with the standard. Each contract manager is responsible for reviewing notices of noncompliance. In addition, once a plan has completed any necessary corrective action, the standard is designated as *Met*.

Corrective Actions

AHCA's analysis of the documents and other data gathered from desk and on-site reviews result in a determination of compliance. In some cases, plans can either be in compliance (*Met*), or they receive a *Partially Met* or *Not Me*t designation. If a standard is *Not Met*, the plan may receive a compliance action which requires a corrective action plan (CAP) and/or other actions such as sanctions or LDs, which are communicated to the plan in a formal letter. The letter describes how the plan failed to provide services to enrollees.

All plans are given an opportunity to dispute the imposition of a penalty by submitting a written dispute directly to the Medicaid director or designee. The dispute must be received by AHCA within 21 days after the plan receives notice that a penalty was imposed.

Plan-Specific Results

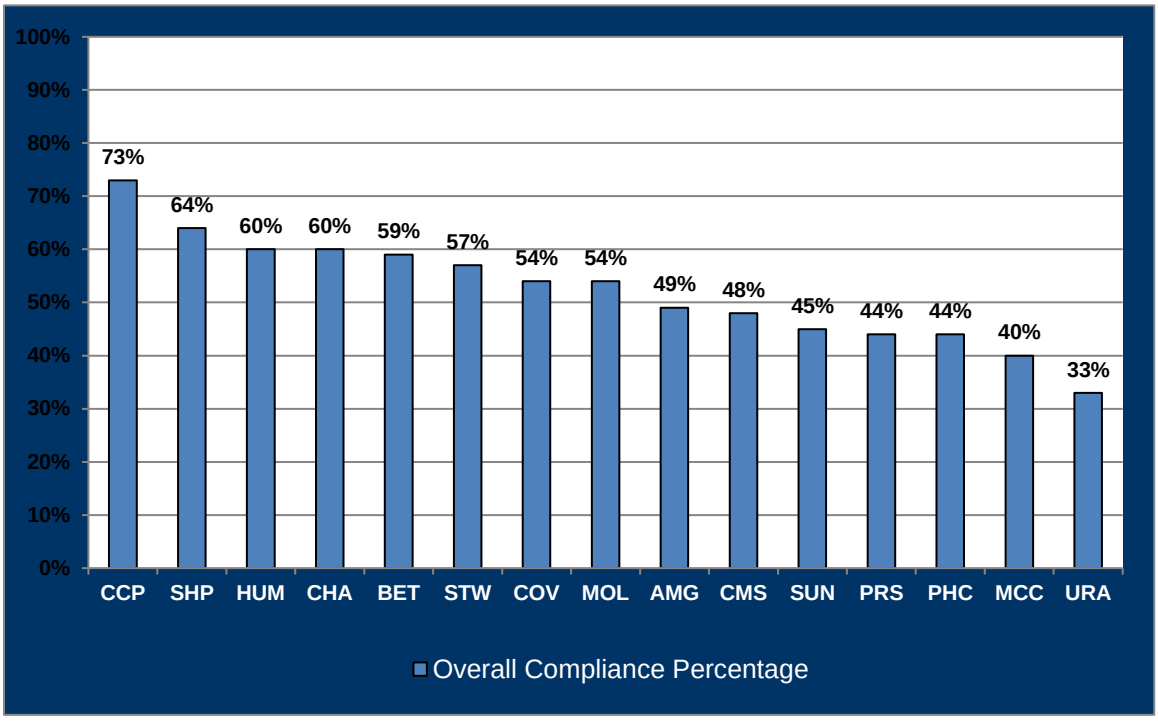
For the SFY 2017–2018 review, AHCA conducted a focused monitoring review of the health plans related to their performance in the care of pregnant women and newborn children. AHCA provided HSAG with a copy of the draft report titled *Review of Prenatal, Postpartum, and Newborn Services* (Report). AHCA reported that overall compliance with contract requirements was assessed based on scores derived through a review of each plan's policies and procedures, and review of plan operations through a sample of medical files for pregnant women and their infants. AHCA concluded that no plan achieved 100 percent compliance and there are a number of opportunities to improve overall compliance. HSAG has included in this technical report the results of the monitoring AHCA performed during SFY 2017–2018.

AHCA performed ongoing monitoring of contract requirements, measuring each plan's compliance with specific requirements and standards designed to ensure quality care for pregnant women and their newborns (e.g., prenatal and postpartum care, coordination with Healthy Start programs, referral to community resources, such as Women, Infants, and Children (WIC), etc.). Monitoring activities involved:

- Review of complaints, grievances and fair hearing requests to determine the areas of focus for targeted monitoring.
- Review of medical files of plans' providers for enrollees and their infants to monitor service provision.
- Review of plans' policies and procedures related to prenatal, postpartum, and newborn care to ensure compliance with contract requirements.
- Review of compliance actions related to plans' performance.

Figure 4-1 represents the overall compliance by plan as provided to HSAG by the Bureau of Medicaid Quality. The Medicaid Quality recommended compliance actions for all plans.

Figure 4-1—Overall Compliance Percentage by Plan



AHCA identified opportunities to enhance ongoing monitoring of managed care plan to ensure they are deploying strategies to address the following:

- Enhanced monitoring of network providers of prenatal, newborn, and postpartum services
- Improved provider awareness and engagement in specific, measurable goals
- Implementation of evidence-based, research-informed practices to improve birth outcomes
- Process improvement for care coordination
- Improvement in enrollee follow-up and engagement
- Improved enforcement by the plan of its policies and procedures for care
- More collaboration with community resources, including Healthy Start coalitions

In addition to the plan-specific targeted monitoring described above, AHCA engaged in a number of other plan-specific monitoring activities throughout the year that identified areas of non-compliance and resulted in liquidated damages and/or sanctions. Table 4-1 includes the final actions for the SMMC plans by issue type that AHCA performed during SFY 2017–2018, including an aggregation of all compliance actions, LDs, and sanctions assigned by AHCA per plan.

Table 4-1—SMMC Final Actions by Issue Type Q1–Q4 SFY17/18[+]

Plan Name	Marketing	Enrollee Services and Grievances	Medicaid Fair Hearing	Covered Services	Provider Network	Quality and Utilization Management	Administration and Management	Finance	Reporting	Total Number of Actions	Total LD Dollar Amount[+]	Total Sanction Dollar Amount[+]
Positive	1	1	0	0	7	2	1	0	1	**13**	**$3,000**	**$0**
Amerigroup	0	2	0	3	9	6	13	1	7	**41**	**$1,176,225**	**$0**
Better Health	0	0	0	1	4	1	4	1	2	**13**	**$568,800**	**$0**
Community Care Plan	0	1	0	0	2	1	3	1	4	**12**	**$313,100**	**$0**
Clear Health	0	1	0	2	4	2	3	0	3	**15**	**$122,200**	**$0**
Children's Medical Service	0	0	0	0	0	0	0	0	0	**0**	**$0**	**$0**
Aetna Better Health	0	1	0	1	4	4	4	0	3	**17**	**$611,050**	**$0**
Freedom	0	0	0	0	1	0	0	0	0	**1**	**$43,203**	**$0**
Humana	1	3	0	3	10	3	7	0	5	**32**	**$1,998,850**	**$0**
Magellan	0	0	0	0	3	3	1	1	2	**10**	**$2,451,775**	**$0**
Molina	3	0	0	2	9	6	5	0	4	**29**	**$3,794,550**	**$150,000**
Prestige	0	2	0	2	8	2	1	0	3	**18**	**$2,916,500**	**$2,500**
Simply	2	1	0	1	5	1	1	1	3	**15**	**$226,300**	**$0**
Staywell	1	2	0	6	9	3	7	0	4	**32**	**$2,559,650**	**$5,000**
Sunshine	0	1	0	4	10	7	3	1	4	**30**	**$6,742,350**	**$0**
United	2	6	3	10	11	5	6	1	3	**47**	**$2,863,750**	**$2,500**
TOTAL	**7**	**24**	**3**	**35**	**96**	**46**	**59**	**7**	**48**	**325**	**$26,391,303**	**$160,000**

[+]**Source:** *Florida Medicaid SMMC Compliance Actions Q1–Q4 FY17/18.* Available at: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/FY1718_FINAL_Compliance_Actions.pdf. Accessed on: Feb 1, 2019.

Recommendations

HSAG established that in accordance with 42 CFR §438.66 State monitoring requirements, AHCA conducted compliance and monitoring activities throughout SFY 2016–2017. AHCA has a

comprehensive system that monitors all contract requirements and most of the federal standards for the plans.

HSAG recommends that, in accordance with 42 CFR §438.358(b)(1)(iii), AHCA enhance the monitoring system already in place to include all federal requirements to determine each plan's adherence to the standards in subparts D and E.

In addition to a comprehensive three-year compliance review, HSAG recommends the following for AHCA:

- Establish an agency-wide methodology when conducting monitoring and review activities to provide a uniform method of ensuring that plans meet the federal and State requirements for managed care programs.
- Develop a standardized tool to allow multiple AHCA groups to document compliance with an established threshold and determine the plans as fully compliant only when all elements of the standard are present.
- Produce a summary document that details the plans' noncompliance with contract requirements and/or federal standards so that the plans can make improvements.
- Determine which plans and which standard categories need more TA to improve performance, based on information from the compliance review and monitoring that occurs throughout the year.

HSAG recommends the following for the plans:

- Concentrate improvements on the prenatal, postpartum, and newborn services as there appear to be opportunities for improvement as noted in the draft *Review of Prenatal, Postpartum, and Newborn Services* report completed by the AHCA Bureau of Medicaid Quality.
- Anticipate compliance reviews and maintain a checklist of compliance activities to determine internal issues with their own processes. The plans could use the federal standards as required and conduct internal risk assessments to identify and promptly address any deficiencies.
- Concentrate improvement efforts on all standards and contract requirements, especially those related to the following:
  - Provider Network
  - Administration and Management
  - Reporting
  - Quality and Utilization Management
  - Covered Services
  - Enrollee Services and Grievances

5. Performance Measures

Objectives

HSAG's role in the validation of performance measures for each plan type was to ensure that validation activities were conducted as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012 (CMS Performance Measure Validation Protocol, cited earlier in this report). This included reviewing the independent auditing process to ensure key audit activities were performed, and verifying that performance measure rates were collected, reported, and calculated according to the specifications required by the State.

For MMA Standard and Specialty plans (collectively referred to as "MMA plans" in this section), AHCA required that the MMA plans undergo an NCQA HEDIS Compliance Audit on the performance measures selected for reporting. All measure indicator data were audited by each MMA plan's NCQA-licensed organizations (LOs). To avoid any redundancy in the auditing process, HSAG evaluated the NCQA HEDIS Compliance Audit process for consistency with the CMS protocol.

For the LTC plans, AHCA required that the plans undergo a PMV audit conducted by an external audit firm in accordance with the CMS protocol. However, since some of the measures required to be reported follow the HEDIS measure specifications, AHCA intended that an NCQA HEDIS Compliance Audit be conducted to the extent possible. Based on FAR reviews, HSAG found that for the current year, all LTC plans' audits were conducted following the NCQA HEDIS Compliance Audit policies and procedures.

Methodology/Technical Methods of Data Collection and Analysis

HSAG followed two technical methods: one method for the MMA Standard and Specialty plans and one method for the LTC plans. For the MMA plans, HSAG requested the performance measure report and FAR generated by the LO for each plan. These documents, which were used and/or generated by the MMA plans and their auditors during the NCQA HEDIS Compliance Audit, were reviewed by HSAG to verify the extent to which critical audit steps were followed during the audit. For the LTC plans, HSAG obtained a list of the performance measures specified in the Statewide Medicaid Managed Care (SMMC) program contract that were required for validation. HSAG requested the FAR and performance measure report generated by the auditor for each LTC plan. The performance measure report contained all rates calculated and reported by the LTC plan. According to AHCA's reporting requirements, these rates were also audited by the plan's LO.

MMA Plans

Table 5-1 presents critical elements and approaches that HSAG used to conduct the PMV activities for the MMA plans.

Table 5-1—Key PMV Steps Performed by HSAG for MMA Plans

PMV Step	Associated Activities Performed by HSAG
Pre-On-Site Visit Call/Meeting	HSAG verified that the LOs addressed key topics such as timelines and on-site review dates.
HEDIS Record of Administration, Date Management, and Processes (Roadmap) Review	HSAG examined the completeness of the Roadmap and looked for evidence in the FARs that the LOs completed a thorough review of all Roadmap components.
Software Vendor	If an MMA plan used a software vendor to produce measure rates, HSAG assessed whether or not the MMA plan contracted with a vendor that achieved full measure certification status by NCQA for the reported HEDIS measure. Where applicable, the NCQA Measure Certification letter was reviewed to ensure that each measure was under the scope of certification. Otherwise, HSAG examined whether source code review was conducted by the LOs (see next step below).
Source Code Review	HSAG ensured that if a software vendor with certified HEDIS measures was not used, the LOs reviewed the MMA plan's programming language for HEDIS measures. For all non-HEDIS measures, HSAG ensured that the LOs reviewed the plan's programming language. Source code review was used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (ensuring that rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).
Primary Source Verification	HSAG verified that the LOs conducted appropriate checks to ensure that records used for performance measure reporting match with the primary data source. This step occurs to determine the validity of the source data used to generate the measure rates.
Supplemental Data Validation	If the MMA plan used any supplemental data for reporting, the LO was to validate the supplemental data according to NCQA's guidelines. HSAG verified whether or not the LO was following the NCQA-required approach while validating the supplemental database.
Convenience Sample Validation	HSAG verified that, as part of the medical record review validation (MRRV) process, the LOs identified whether or not the MMA plan was required to prepare a convenience sample, and if not, whether specific reasons were documented.
MRRV	HSAG examined whether or not the LOs performed a re-review of a random sample of medical records based on NCQA MRRV protocol to ensure the reliability and validity of the data collected.

PMV Step	Associated Activities Performed by HSAG
Health Plan Quality Indicator Data File Review	The MMA plans are required to submit a health plan quality indicator data file for the submission of audited rates to AHCA. The file should comply with the AHCA-specified reporting format and contain the denominator, numerator, and reported rate for each performance measure. HSAG evaluated whether there was any documentation in the FAR to show that the LOs performed a review of the health plan quality indicator data file.

LTC Plans

HSAG reviewed the FARs and the performance measure reports to verify the extent to which critical audit activities were performed. The review included the following PMV activities for the LTC plans:

- Verify that key audit elements were performed by the plan's LO to ensure the audit was conducted in compliance with NCQA policies and procedures.
- Examine evidence that the auditors completed a thorough review of the Roadmap components associated with calculating and reporting performance measures outlined by AHCA.
- Identify that, regarding plans for which an NCQA HEDIS Compliance Audit was performed, the IS standards (systems, policies, and procedures) applicable for performance measure reporting were reviewed and results were documented by the auditor.
- Evaluate the auditor's description and audit findings regarding data systems and processes associated with performance measure production for plans where NCQA HEDIS Compliance Audit procedures were not referenced in the FAR.

HSAG also validated the LTC plans' audited rates in the performance measure reports, focusing on the following verification components:

- Compare the audit designation results listed in the FAR to the actual rates reported in the performance measure report to ensure that the designation is appropriately applied.
- Assess the accuracy of the rate calculated based on the denominator and numerator for each measure.
- Evaluate data reasonableness for measures with similar eligible populations.
- Assess the extent to which all data elements are reported according to the requirements listed in the *AHCA Health Plan Report Guide.*[5-1]

Plan-Specific Results

MMA/Specialty Plans

AHCA required that each MMA plan undergo an NCQA HEDIS Compliance Audit of the performance measures selected for reporting. These audits were performed by NCQA-LOs in 2018, on data collected during CY 2017.

[5-1] Agency for Health Care Administration. Statewide Medicaid Managed Care (SMMC) Managed Care Plan Report Guide Effective 10-1-16. Available at: https://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/Report_Guides/Oct_2016/SMMC_Report_Guide_effective_10012016.pdf. Accessed on: Feb 19, 2019.

Results by Domain

The results sections below discuss the statewide average performance as compared to the AHCA-identified performance targets and statewide rate increases or decreases from RY 2017 to RY 2018.

Please refer to Appendix D. MCO Performance Measure Results to review the plan-specific ratings by measure.

Results—Pediatric Care

Table 5-2 displays the statewide averages calculated by HSAG for RY 2017 and RY 2018 for all measures in the Pediatric Care domain. As shown by measures shaded in gray in the table, AHCA established performance targets for 12 of the 14 measure indicators in this domain. Cells shaded in green indicate performance rates that met or exceeded AHCA's RY 2018 performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for RY 2018. Please note that only measures with an established performance target were compared to the minimum performance target. To review the Pediatric Care measure rates by plan, please see Appendix D. MCO Performance Measure Results.

Table 5-2—Florida Medicaid Performance Measure Result Summary Table, Pediatric Care

Measure	Measure Source	RY 2017	RY 2018
Pediatric Care			
Well-Child Visits in the First 15 Months of Life			
*No Well-Child Visits**	HEDIS	1.97%	1.97%
Six or More Well-Child Visits	HEDIS	63.50%	69.48%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	HEDIS	75.66%	77.94%
Childhood Immunization Status			
Combination 2	HEDIS	78.21%	78.16%
Combination 3	HEDIS	74.22%	73.71%
Lead Screening in Children			
Lead Screening in Children	HEDIS	65.85%	67.48%

Measure	Measure Source	RY 2017	RY 2018
Follow-Up Care for Children Prescribed ADHD Medication[1]			
Initiation Phase	HEDIS	48.55%	48.22%
Continuation and Maintenance Phase	HEDIS	65.09%	63.90%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	HEDIS	78.40%	82.76%
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	HEDIS	52.91%	57.22%
Immunizations for Adolescents			
Combination 1	HEDIS	70.62%	71.93%
Combination 2[2]	HEDIS	—	30.45%
Annual Dental Visit			
Total	HEDIS	48.55%	50.87%
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk[3]			
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	Medicaid Child Core Set	30.41%	28.26%

** Indicates that lower rates are better for this measure.*

— indicates that the RY 2017 rate is not presented because the MMA plans were not required to report the measure until RY 2018. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2017 rate is not displayed.

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.

[2] Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between RY 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks were not performed for this measure.

[3] AHCA did not set a performance target for this measure for 2018; therefore, comparisons to benchmarks were not performed for this measure.

Indicates that AHCA established a performance target for the measure for RY 2018.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

Three of 12 (25.0 percent) statewide average rates within the Pediatric Care domain met or exceeded AHCA's RY 2018 performance targets (*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*). Additionally, three measure rates (*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* , *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, and *Adolescent Well-Care Visits*) had rate increases of more than 4 percentage points from RY 2017 to RY 2018. Conversely, four of 12 (33.3 percent) statewide rates (*Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*, *Lead Screening in Children*, *Immunizations*

for Adolescents—Combination 1, and *Annual Dental Visit—Total*) fell below the minimum performance target, indicating opportunities for improvement.

Results—Women's Care

Table 5-3 displays the statewide averages calculated by HSAG for RY 2017 and RY 2018 for all measures in the Women's Care domain. As shown by measures shaded in gray in the table, AHCA established performance targets for four of the 13 measure indicators in this domain. Cells shaded in green indicate performance rates that met or exceeded AHCA's RY 2018 performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for RY 2018. Please note that only measures with an established performance target were compared to the minimum performance target. To review the Women's Care measure rates by plan, please see Appendix D. MCO Performance Measure Results.

Table 5-3—Florida Medicaid Performance Measure Result Summary Table, Women's Care

Measure	Measure Source	RY 2017	RY 2018
Women's Care			
Cervical Cancer Screening			
Cervical Cancer Screening	HEDIS	56.08%	59.84%
Chlamydia Screening in Women			
Total	HEDIS	62.55%	64.31%
Breast Cancer Screening[1]			
Breast Cancer Screening	HEDIS	—	58.17%
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	HEDIS	84.26%	81.93%
Postpartum Care	HEDIS	63.55%	64.54%
Contraceptive Care—Postpartum Women			
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	Medicaid Child Core Set	—	1.00%
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	Medicaid Child Core Set	—	35.57%
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	Medicaid Child Core Set	—	0.03%
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	Medicaid Child Core Set	—	7.40%
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	Medicaid Adult Core Set	—	10.83%

Measure	Measure Source	RY 2017	RY 2018
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	Medicaid Adult Core Set	—	39.41%

Measure	Measure Source	RY 2017	RY 2018
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	Medicaid Adult Core Set	—	0.05%
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	Medicaid Adult Core Set	—	6.65%

[1]Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between RY 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks were not performed for this measure.

— indicates that the RY 2017 rate is not presented because the MMA plans were not required to report the measure until RY 2018. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2017 rate is not displayed.

Indicates that AHCA established a performance target for the measure for RY 2018.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

At the statewide level, only one of four (25.0 percent) statewide rates in the Women's Care domain (*Chlamydia Screening in Women—Total*) met AHCA's RY 2018 performance target. Additionally, the statewide rate for *Prenatal and Postpartum—Timeliness of Prenatal Care* was both the only measure indicator within the Women's Care domain to demonstrate a decline in performance from RY 2017 to RY 2018 and the only statewide rate to fall below the minimum performance target, indicating opportunities for improvement for this measure.

Results—Living With Illness

Table 5-4 displays the statewide averages calculated by HSAG for RY 2017 and RY 2018 for all measures in the Living With Illness domain. As shown by measures shaded in gray in the table, AHCA established performance targets for 11 of the 21 measure indicators in this domain. Cells shaded in green indicate performance rates that met or exceeded AHCA's RY 2018 performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for RY 2018. Please note that only measures with an established performance target were compared to the minimum performance target. To review the Living With Illness measure rates by plan, please see Appendix D. MCO Performance Measure Results.

Table 5-4—Florida Medicaid Performance Measure Result Summary Table, Living With Illness

Measure	Measure Source	RY 2017	RY 2018
Living With Illness			
Comprehensive Diabetes Care			
HbA1c Testing	HEDIS	81.95%	85.69%
*HbA1c Poor Control (>9.0%)**	HEDIS	45.41%	40.90%
HbA1c Control (<8.0%)	HEDIS	44.09%	49.22%
Eye Exam (Retinal) Performed	HEDIS	55.87%	55.26%
Medical Attention for Nephropathy	HEDIS	90.91%	92.88%

Measure	Measure Source	RY 2017	RY 2018
Controlling High Blood Pressure			
Controlling High Blood Pressure	HEDIS	54.85%	55.03%
Adult BMI Assessment			
Adult BMI Assessment	HEDIS	87.21%	89.68%
Medication Management for People With Asthma			
Medication Compliance 50%—Total	HEDIS	54.00%	55.35%
Medication Compliance 75%—Total	HEDIS	28.82%	28.98%
Annual Monitoring for Patients on Persistent Medications[1]			
Total	HEDIS	—	92.92%
Plan All-Cause Readmissions			
*18–64 Years—Total**	Medicaid Adult Core Set	24.01%	23.24%
*65+ Years—Total**	Medicaid Adult Core Set	13.45%	13.56%
HIV Viral Load Suppression[2]			
18–64 Years	Medicaid Adult Core Set	13.62%	10.80%
65+ Years	Medicaid Adult Core Set	6.53%	4.10%
Medical Assistance With Smoking and Tobacco Use Cessation[3]			
Advising Smokers and Tobacco Users to Quit—Total	HEDIS	41.23%	82.23%
Discussing Cessation Medications—Total	HEDIS	27.64%	56.73%
Discussing Cessation Strategies—Total	HEDIS	25.59%	51.50%
Care for Older Adults			
Advance Care Planning—66+ Years	HEDIS	85.19%	75.41%
Functional Status Assessment—66+ Years	HEDIS	90.74%	86.89%
Medication Review—66+ Years	HEDIS	94.44%	88.52%
Pain Assessment—66+ Years	HEDIS	96.30%	90.16%

** Indicates that lower rates are better for this measure.*

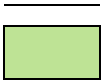
[1] Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between RY 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks were not performed for this measure.

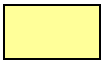
[2] Due to issues associated with the plans obtaining complete HIV/AIDS lab data for this measure, low rates may be associated with a lack of complete data rather than cases of non-suppression of HIV viral load. Therefore, caution should be exercised when interpreting results.

[3] To align with calculations from prior years, the weighted average for this measure used the eligible population for the survey rather than the number of people who responded as being smokers.

— indicates that the RY 2017 rate is not presented because the MMA plans were not required to report the measure until RY 2018. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2017 rate is not displayed.

Indicates that AHCA established a performance target for the measure for RY 2018.

 *Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.*

 *Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.*

Four of 11 (36.4 percent) statewide average rates met AHCA's RY 2018 performance targets in the Living With Illness domain (*Comprehensive Diabetes Care—Medical Attention for Nephropathy*; *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total*, *Discussing Cessation Medications—Total*, and *Discussing Cessation Strategies—Total*). Additionally, 10 of 11 (90.9 percent) statewide average rates demonstrated improvement from RY 2017 to RY 2018. Of note, the statewide average rates for all the *Medical Assistance With Smoking and Tobacco Use Cessation* measure indicators increased by 25 percentage points or more from RY 2017 to RY 2018. Conversely, three of 11 (27.3 percent) RY 2018 statewide average rates ranked below the minimum performance target (*Comprehensive Diabetes Care—HbA1c Testing*, *Controlling High Blood Pressure*, and *Medication Management for People With Asthma—Medication Compliance 75%—Total).*

Results—Behavioral Health

Table 5-5 displays the statewide averages calculated by HSAG for RY 2017 and RY 2018 for all measures in the Behavioral Health domain. As shown by measures shaded in gray in the table, AHCA established performance targets for seven of the 16 measure indicators in this domain. None of the RY 2018 measure indicators met or exceeded the minimum performance targets for RY 2018; therefore, no cells are shaded green. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for RY 2018. Please note that only measures with an established performance target were compared to the minimum performance target. To review the Behavioral Health measure rates by plan, please see Appendix D. MCO Performance Measure Results.

Table 5-5—Florida Medicaid Performance Measure Result Summary Table, Behavioral Health

Measure	Measure Source	RY 2017	RY 2018
Behavioral Health			
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]			
Initiation of AOD Treatment—Total—Total	HEDIS	—	41.80%
Engagement of AOD Treatment—Total—Total	HEDIS	—	6.90%
Follow-Up After Hospitalization for Mental Illness[1]			
7-Day Follow-Up	HEDIS & AHCA-Defined	—	30.52%
30-Day Follow-Up	HEDIS & AHCA-Defined	—	51.14%
Follow-Up After ED Visit for Mental Illness[2]			
7-Day Follow-Up	HEDIS	33.05%	28.05%
30-Day Follow-Up	HEDIS	51.14%	45.22%

Measure	Measure Source	RY 2017	RY 2018
Follow-Up After ED Visit for AOD Abuse or Dependence[2]			
7-Day Follow-Up—Total	HEDIS	9.69%	5.52%
30-Day Follow-Up—Total	HEDIS	12.30%	8.21%
Antidepressant Medication Management[2]			
Effective Acute Phase Treatment	HEDIS	51.38%	52.58%
Effective Continuation Phase Treatment	HEDIS	35.72%	37.21%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS	63.31%	62.68%
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Total	HEDIS	38.06%	38.90%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents			
*Total**	HEDIS	1.64%	1.71%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]			
Total	HEDIS	—	62.63%
Mental Health Readmission Rate			
*Mental Health Readmission Rate**	AHCA-Defined	33.52%	40.92%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS	80.62%	80.75%

** Indicates that lower rates are better for this measure.*

[1] Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between RY 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks were not performed for this measure.

[2] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.

— indicates that the RY 2017 rate is not presented because the MMA plans were not required to report the measure until RY 2018. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2017 rate is not displayed.

Indicates that AHCA established a performance target for the measure for RY 2018.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

No statewide average rates in the Behavioral Health domain met AHCA's RY 2018 performance targets, indicating statewide opportunities for improvement exist related to behavioral health; however, only one out of seven (14.3 percent) statewide average rates fell below the minimum performance target (*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*).

Results—Access/Availability of Care

Table 5-6 displays the statewide averages calculated by HSAG for RY 2017 and RY 2018 for all measures in the Access/Availability of Care domain. As shown by measures shaded in gray in the table, all six measure indicators reported for RY 2018 had a performance target established by AHCA. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for RY 2018. To review the Access/Availability of Care measure rates by plan, please see Appendix D. MCO Performance Measure Results.

Table 5-6—Florida Medicaid Performance Measure Result Summary Table, Access/Availability of Care

Measure	Measure Source	RY 2017	RY 2018
Access/Availability of Care			
Children and Adolescents' Access to Primary Care Practitioners			
12–24 Months	HEDIS	94.37%	94.62%
25 Months–6 Years	HEDIS	87.82%	87.84%
7–11 Years	HEDIS	88.75%	88.21%
12–19 Years	HEDIS	85.16%	84.46%
Adults' Access to Preventive/Ambulatory Health Services			
Total	HEDIS	74.11%	75.50%
Call Answer Timeliness[1]			
Call Answer Timeliness	AHCA-Defined	87.70%	90.48%

** For this indicator, a lower rate indicates better performance.*

[1] *Current benchmarks are not available for this measure, as it was retired for RY 2017. Therefore, 2018 performance levels were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for RY 2015 (the most recent year available).*

Indicates that AHCA established a performance target for the measure for RY 2018.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

One of six (16.7 percent) statewide rates met AHCA's RY 2018 performance targets (*Call Answer Timeliness*). The remaining five measure indicator rates fell below the minimum performance targets, indicating opportunities for improvement related to Access/Availability of Care.

Results—Use of Services

Table 5-7 displays the statewide averages for RY 2017 and RY 2018 of all measures in the Use of Services domain. Of note, Use of Services data are descriptive and are evaluated to monitor healthcare utilization patterns over time. Assessment of utilization should be based on the characteristics of the MMA plans' populations and service delivery models. As shown by measures shaded in gray, AHCA established performance targets for one of the six measure indicators in this domain. None of the RY 2018 measure indicators met or exceeded the minimum performance targets for RY 2018; therefore, no cells are shaded green. Cells shaded in yellow indicate performance rates that fell below the minimum

performance target for RY 2018. Please note that only measures with an established performance target were compared to the minimum performance target. To review the Use of Services measure rates by plan, please see Appendix D. MCO Performance Measure Results.

Table 5-7—Florida Medicaid Performance Measure Result Summary Table, Use of Services

Measure	Measure Source	RY 2017	RY 2018
Use of Services			
Ambulatory Care (per 1,000 Member Months)			
Outpatient Visits—Total	HEDIS	320.89	320.24
*ED Visits—Total**	HEDIS	71.22	70.09
Use of Opioids at High Dosage			
*Use of Opioids at High Dosage**	HEDIS	—	87.31
Use of Opioids From Multiple Providers			
*Multiple Prescribers**	HEDIS	—	280.89
*Multiple Pharmacies**	HEDIS	—	154.51
*Multiple Prescribers and Multiple Pharmacies**	HEDIS	—	124.11

** Indicates that lower rates are better for this measure.*

Indicates that AHCA established a performance target for the measure for RY 2018.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

The RY 2018 statewide performance for *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* fell below the minimum performance target, indicating an opportunity for improvement related to Use of Services.

Conclusions and Recommendations

During SFY 2017–2018, all plans were required to undergo an NCQA HEDIS Compliance Audit for those performance measures they were contracted to perform on and report to AHCA. Based on the FARs and supporting documents submitted to HSAG for validation, all MMA Standard and Specialty plans were fully compliant with the following NCQA HEDIS Compliance Audit Standards: IS 2.0 (Enrollment Data), IS 3.0 (Practitioner Data), IS 5.0 (Supplemental Data), and IS 7.0 (Data Integration).

All MMA Specialty plans and all but one MMA Standard plan were fully compliant with IS 1.0 (Medical Services Data). The one MMA Standard plan that was not compliant with IS 1.0 was not compliant with lab services and data processing because the plan's lab vendor did not release HIV/AIDS lab data due to enrollee confidentiality concerns. As a result, the plan was unable to report the *HIV Viral Load Suppression* measure and received a *BR* audit designation for this measure.

Further, all MMA Specialty plans and all but one MMA Standard plan were fully compliant with IS Standard 4.0 (Medical Record Review Processes). One MMA plan had a minimal impact finding with this standard because exclusion errors were identified with the *Prenatal and Postpartum Care* and *Comprehensive Diabetes Care* measures. Since the total number of exclusions was less than 16, and the other nine exclusions passed, no remediation process was required. The exclusions that were not

validated were required to be placed back into the denominator for the two measures, bringing the measures into compliance with IS Standard 4.0.

Overall, 32 statewide MMA plan rates fell below AHCA's performance targets, and nine exceeded the performance targets. While opportunities for improvement exist in almost all domains of care, HSAG offers the following recommendations:

- HSAG recommends that improvement efforts be focused on measures with RY 2018 rates falling below AHCA's performance targets by at least 10 percentage points, as listed below.
  1. **Pediatric Care—***Lead Screening in Children, Immunizations for Adolescents—Combination 1*, and *Annual Dental Visit—Total*
  2. **Living With Illness—***Medication Management for Patients on Persistent Medications—Medication Compliance 75%—Total*.
  3. **Access/Availability of Care—***Adults' Access to Preventive/Ambulatory Health Services—Total*

- HSAG recommends that MMA plans develop improvement strategies to target the measures listed above. For example, MMA plans could investigate root causes associated with low performance based on the care provided to children and thereby target improvement activities that could increase compliance on numerous indicators of care such as *Immunizations for Adolescents*.

LTC Plans

Six LTC plans were contracted with AHCA for providing long-term care services to Medicaid enrollees. The LTC plans were required to report select performance measures for SFY 2017–2018 including 12 performance measure indicators using CY 2017 data (see Table 5-8). The LTC plans underwent a PMV audit to ensure that the rates calculated and reported for these measures were valid and accurate. AHCA intended that an NCQA HEDIS Compliance Audit be conducted for all LTC plans to the extent possible. All audits were conducted by LOs.

Table 5-8—RY 2018 LTC Performance Measures

RY 2018 (CY 2017) Measures	Measure Source
Care for Adults (CFA)—Advance Care Planning—Total, Medication Review—Total, and *Functional Status Assessment—Total*	HEDIS & AHCA-Defined
*Call Answer Timeliness (CAT)^*	AHCA-Defined
Required Record Documentation (RRD)—701B Assessment, Plan of Care—Enrollee Participation, Plan of Care—Primary Care Physician (PCP) Notification, Freedom of Choice Form, and *Plan of Care—LTC Service Authorizations*	AHCA-Defined
Face-to-Face Encounters (F2F)	AHCA-Defined
Case Manager Training (CMT)	AHCA-Defined
Timeliness of Services (TOS)	AHCA-Defined

Note: Cells shaded gray indicate the measures with a RY 2018 performance target established by AHCA.

^ *Current benchmarks are not available for this measure, as it was retired for RY 2017. Therefore, 2018 performance levels were compared to NCQA's Quality Compass national Medicaid All Lines of Business percentiles for RY 2015 (the most recent year available).*

Results

Table 5-9 displays the LTC program statewide averages for RY 2017 and RY 2018 for the LTC measures. The *Call Answer Timeliness* measure is shaded gray to indicate that this is the only measure with a 2018 performance target established by AHCA. None of the RY 2018 measure indicators fell below the minimum performance target for RY 2018; therefore, no cells are shaded yellow.

Table 5-9—Florida Medicaid LTC Program Weighted Averages

Measure	RY 2017	RY 2018
LTC		
Care for Adults		
Advance Care Planning—Total	83.99%	94.70%
Medication Review—Total	31.85%	79.40%
Functional Status Assessment—Total	92.38%	93.21%
Call Answer Timeliness[1]		
Call Answer Timeliness	87.87%	93.86%
Required Record Documentation		
701B Assessment	89.71%	96.12%
Plan of Care—Enrollee Participation	73.71%	74.71%
Plan of Care—PCP Notification	56.51%	64.18%
Freedom of Choice Form	84.39%	82.06%
*Plan of Care—LTC Service Authorizations**	0.63%	1.08%
Face-to-Face Encounters		
Face-to-Face Encounters	76.41%	84.37%
Case Manager Training		
Case Manager Training	97.01%	96.88%
Timeliness of Service		
Timeliness of Service	71.43%	81.05%

** For this indicator, a lower rate indicates better performance.*

[1] *Current benchmarks are not available for this measure, as it was retired for RY 2017. Therefore, 2018 performance levels were compared to NCQA's Quality Compass national Medicaid All Lines of Business percentiles for RY 2015 (the most recent year available).*

Indicates that AHCA established a performance target for the measure for RY 2018.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

Call Answer Timeliness was the only statewide rate that had a performance target. This statewide rate increased by almost 6 percentage points to exceed AHCA's RY 2018 performance target. Nine of the 12 (75.0 percent) statewide average rates demonstrated improved performance from RY 2017 to RY 2018, with seven of these rates improving by more than 5 percentage points. Of note, the largest rate increase was for *Care for Adults—Medication Review—Total*, with an increase of approximately 48 percentage points, followed by *Care for Adults—Advance Care Planning—Total*, with an increase of approximately 11 percentage points.

Conclusions and Recommendations

The LTC plans were required to report six measures, yielding 12 measure indicators. For the current year, HSAG identified that all the LTC plan audits were conducted following NCQA HEDIS Compliance Audit policies and procedures.

Call Answer Timeliness was the only performance measure that was assigned a performance target by AHCA. The 2018 rate for *Call Answer Timeliness* exceeded AHCA's performance targets by just under 5 percentage points. Although performance improved for most of the statewide average rates from RY 2017 to RY 2018, three measures (*Required Record Documentation—Freedom of Choice Form* and *Plan of* Care—*LTC Service Authorizations*; and *Case Manager Training*) demonstrated a decline in performance; therefore, HSAG offers the following recommendations:

- The statewide average for *Case Manager Training* demonstrated a slight decline from RY 2017 to RY 2018. Additionally, Molina-LTC was the only plan to report a rate of 100 percent for this measure. LTC plans that performed below 100 percent for this measure should investigate the root cause of the noncompliance and ensure proper and timely training of their case managers regarding the mandate to report abuse, neglect, and exploitation.
- *Required Record Documentation* measures assess the percentage of enrollees whose records contained specific documents to be maintained by the LTC plans; therefore, a rate less than 100 percent would imply noncompliance with AHCA's expectation. LTC plans that performed below 100 percent for this measure should investigate the root cause of the noncompliance and ensure proper documentation is maintained for enrollees.
- Some of the AHCA-defined measures rely on data collected outside the usual data systems included in the NCQA HEDIS Compliance Audit policies and procedures, such as the case management system. In the past, HSAG found that the FARs failed to provide adequate detail regarding the validation of data systems outside those typically included in the NCQA HEDIS Compliance Audit. Therefore, HSAG recommends that the FARs include a brief description of those data systems used for calculating AHCA-defined measures.

6. Performance Improvement Projects

During SFY 2017–2018, the MMA plans submitted four PIPs for validation, including the following topics: two state-mandated topics, one additional nonclinical topic, and one additional clinical topic. For the additional clinical topic, the MMA plans were required to select a topic falling into one of three categories: a population health issue within a specific geographic area identified as in need of improvement (such as diabetes, hypertension, or asthma); integration of primary care and behavioral health; or reduction of preventable readmissions. The LTC plans submitted two PIPs for validation, including the following topics: one state-mandated topic and one nonclinical topic. Comprehensive plans that offered services for both the MMA and LTC programs submitted six PIPs for validation, adhering to the PIP topic requirements for both programs. For some of the specialty plans, exceptions were made to the mandated PIP topics when the topic did not apply to the population served. The PIPs validated for SFY 2017–2018 had progressed through the Design stage (Activities I–VI), Implementation stage (Activities VII and VIII), and Outcomes stage (Activity IX and X),[6-1] reporting baseline through Remeasurement 2 study indicator results. One exception was the LTC *Medication Review* PIP, which did not progress beyond Remeasurement 1 due to a shift in the measurement period dates, resulting from a change in the eligible population specifications that occurred after the initial baseline period.

Table 6-1 displays the state-mandated PIP topics for the MMA plans and the LTC plans, as well as the status of each PIP topic.

Table 6-1—Current State-Mandated PIP Topics

State-mandated PIP Topic	Plan Type	Status
Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	MMA Plans	Remeasurement 2 results reported
Preventive Dental Services for Children	MMA Plans	Remeasurement 2 results reported
Medication Review	LTC Plans	Remeasurement 1 results reported

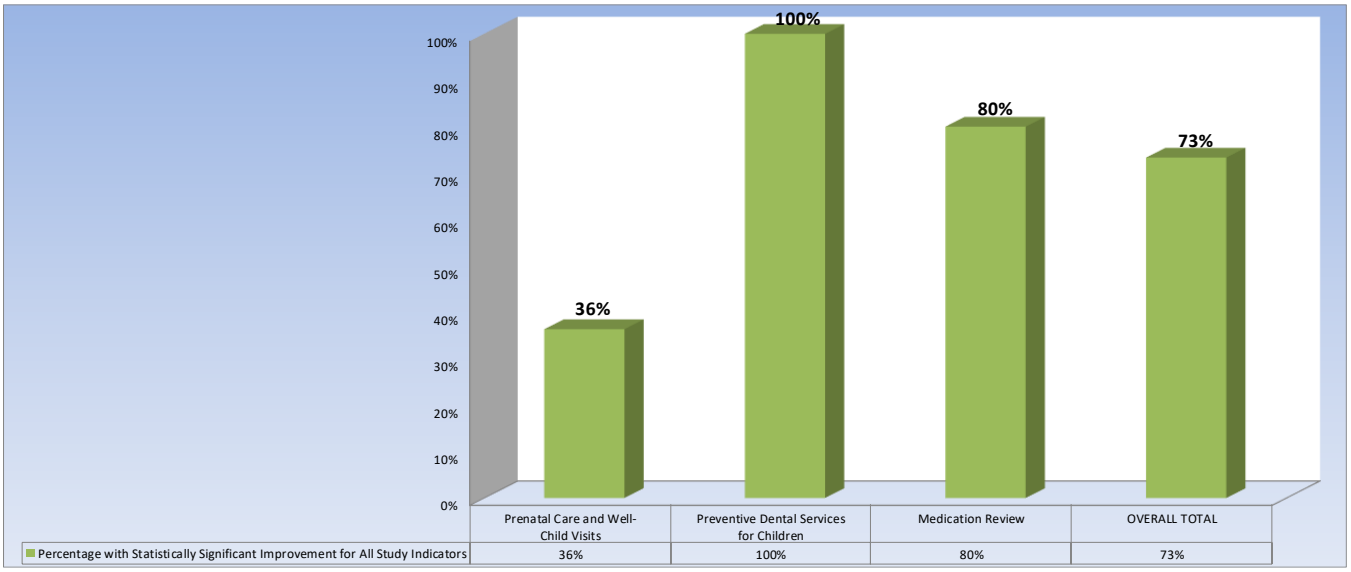
Statistically Significant Improvement

For the SFY 2017–2018 validation cycle, the plans reported Remeasurement 1 and Remeasurement 2 study indicator results, and the PIPs were evaluated for achieving real improvement from baseline to the

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Jan 31, 2019.

most recent remeasurement period. The percentages of state-mandated PIPs that demonstrated statistically significant improvement over baseline across all study indicators are presented in Figure 6-1.

Figure 6-1—Percentage of SFY 2017–2018 State-Mandated PIPs That Achieved Statistically Significant Improvement Over Baseline for All Study Indicators, by PIP Topic



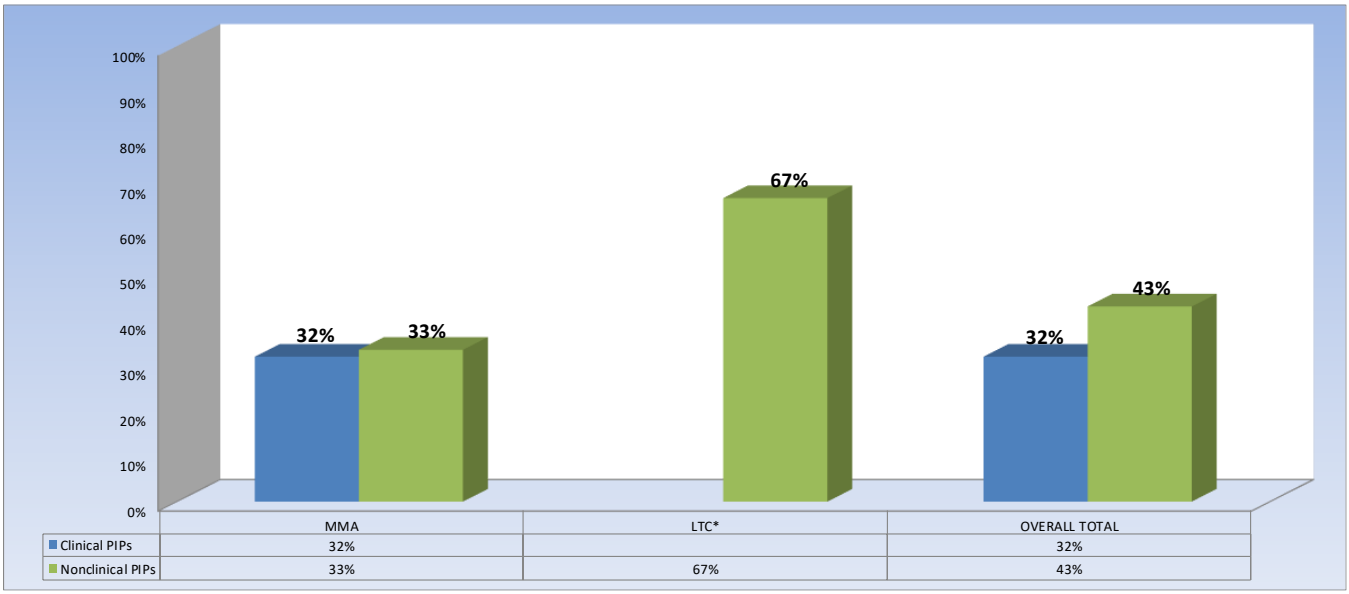
Across the three state-mandated topics, 73 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. The percentage of PIPs demonstrating statistically significant improvement across all study indicators varied by state-mandated topic: 36 percent of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs, 100 percent of the *Preventive Dental Services for Children* PIPs, and 80 percent of the *Medication Review* PIPs.

For this year's validation, PIPs that demonstrated statistically significant improvement across all study indicators last year at Remeasurement 1 and had comparable Remeasurement 2 results reported for this year's validation were assessed for sustained improvement in study indicator outcomes. Among the state-mandated PIPs, HSAG evaluated 17 PIPs (three *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs and all 14 *Preventive Dental Services for Children* PIPs) for sustained improvement, and all 17 PIPs were successful in maintaining the significant improvement over baseline across all study indicators for a second remeasurement. The *Medication Review* PIPs were not assessed for sustained improvement during this year's validation because these PIPs had progressed through the first remeasurement period only. Sustained improvement is not assessed until statistically significant improvement is achieved and results from a subsequent measurement period are reported.

In addition to the state-mandated PIPs represented in Figure 6-1, HSAG evaluated the plan-selected clinical and nonclinical PIPs for achieving real improvement across all study indicators. The percentages

of plan-selected clinical and nonclinical PIPs that demonstrated statistically significant improvement over baseline across all study indicators are presented in Figure 6-2.

Figure 6-2—Percentage of SFY 2017–2018 Plan-Selected Clinical and Nonclinical PIPs That Achieved Statistically Significant Improvement Over Baseline for All Study Indicators, by PIP Topic and Plan Type



	MMA	LTC*	OVERALL TOTAL
Clinical PIPs	32%		32%
Nonclinical PIPs	33%	67%	43%

* The LTC plans did not submit any plan-selected clinical PIPs for validation; therefore, no data are displayed for LTC clinical PIPs.

Thirty-two percent of the clinical PIPs with comparable remeasurement results demonstrated statistically significant improvement over baseline across all study indicators. These results are based on the clinical PIPs conducted by the MMA plans because AHCA did not require the LTC plans to submit plan-selected clinical PIPs for validation during SFY 2017–2018. Among all nonclinical PIPs with comparable remeasurement results, 43 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. A greater percentage of nonclinical PIPs conducted by the LTC plans (67 percent) than conducted by the MMA plans (33 percent) demonstrated statistically significant improvement over baseline across all indicators.

For this year's validation, HSAG also assessed for sustained improvement those plan-selected PIPs that demonstrated statistically significant improvement across all study indicators at Remeasurement 1 and had comparable Remeasurement 2 results reported this year. A pattern like the state-mandated PIPs was seen for the nonclinical plan-selected PIPs in that all four PIPs evaluated for sustained improvement successfully maintained significant improvement across all study indicators for the second remeasurement. The plan-selected clinical PIPs were the only PIPs that did not have a 100 percent success rate in sustained improvement for this year's validation; only one of four clinical PIPs evaluated for sustained improvement was successful at maintaining statistically significant improvement for a second remeasurement period.

Innovative Interventions Associated With Statistically Significant Improvement

As part of the PIP validation process, HSAG identifies innovative interventions employed in PIPs that achieved statistically significant improvement across all study indicators. During the SFY 2017–2018 validation cycle, HSAG identified innovative interventions associated with statistically significant improvement for each of the three state-mandated PIP topics, *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Preventive Dental Visits for Children*, and *Medication Review*. HSAG also identified innovative interventions in three plan-selected clinical PIP topics (*Annual Diabetic Retinal Eye Exam*, *Behavioral Health Screening of CHA [Clear Health Alliance] Members by a PCP [Primary Care Practitioner]* and *Plan All-Cause Readmissions [PCR]*) and one plan-selected nonclinical topic (*Timeliness of Services*). Examples of the innovative interventions include new or redesigned processes for onboarding enrollees and connecting them with services, facilitating partnerships between primary care and dental providers to increase access to preventive dental services, and use of peer support specialists to assist enrollees in pre-discharge planning and scheduling of needed follow-up care after hospitalization.

Overall PIP Validation Status

HSAG validated PIPs submitted by all plans as required by the EQRO contract. The outcome of the validation process was an overall validation status finding for each PIP of *Met*, *Partially Met*, or *Not Met*. To determine the overall validation status for each PIP, HSAG evaluated the PIP on a set of standard evaluation elements that aligned with the three PIP stages—Design, Implementation, and Outcomes—and the 10 steps in CMS' *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[6-2] HSAG designated some evaluation elements as critical because of their importance in defining a project as valid and reliable. Each PIP was evaluated on up to 29 elements, 14 of which are deemed critical and must receive a *Met* score for the PIP to receive a *Met* overall validation status. The PIP also had to receive a *Met* score for 80 percent or more of all applicable evaluation elements to receive a *Met* overall validation status.

This year's validation was the second year that the PIPs had progressed to the Outcomes stage. The PIPs included study indicator results through the second remeasurement and were assessed for real improvement of outcomes and, in some cases, for sustained improvement. In previous years, the PIPs were evaluated on study design and accuracy of the baseline measurement, having progressed only through the first two of the three PIP stages—Design and Implementation. With progression to the third stage, Outcomes, the PIPs were evaluated on up to three additional critical evaluation elements.

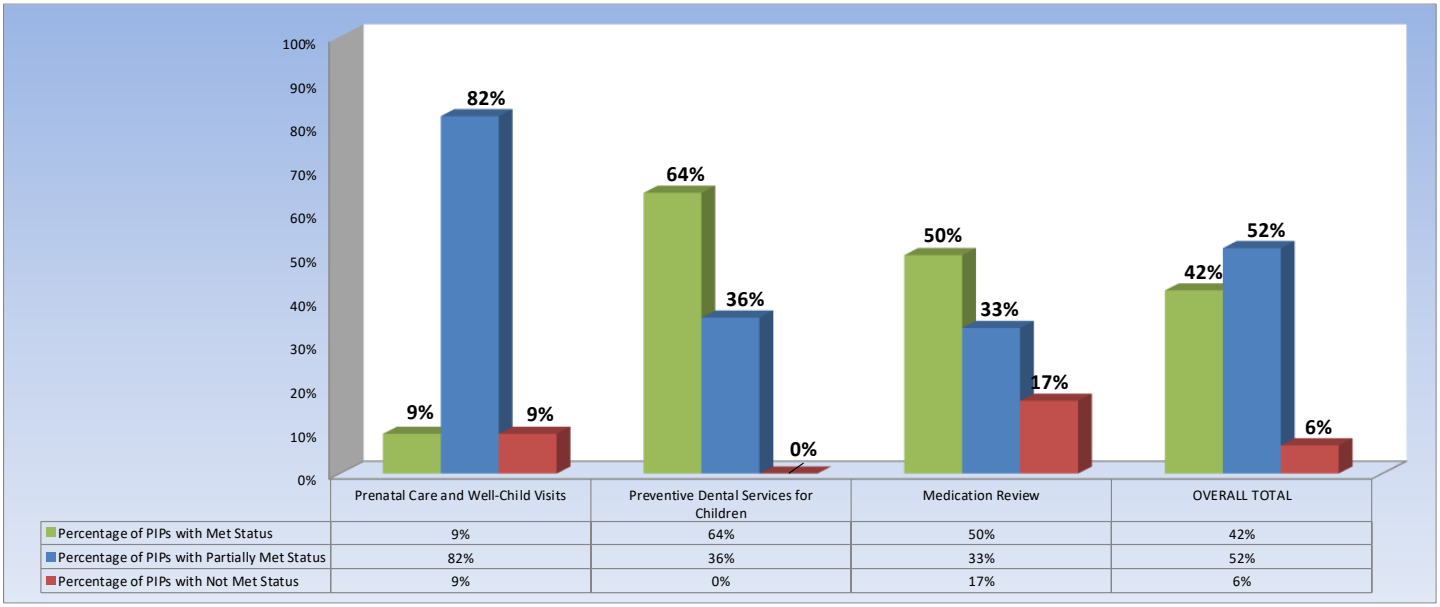
The critical evaluation elements scored when the PIPs progress to the Outcomes stage include one element in Activity VIII (Appropriate Improvement Strategies), one element in Activity IX (Real Improvement), and one element in Activity X (Sustained Improvement). In Activity VIII, the PIPs were evaluated on whether the plans had assessed each intervention for effectiveness and, in Activity IX, the

[6-2] Ibid.

PIPs were evaluated on whether the study indicators' remeasurement rates demonstrated statistically significant improvement over baseline rates. If the PIP documentation did not demonstrate sufficient evaluation of each intervention, one of the critical evaluation elements in Activity VIII would not receive a *Met* score and the overall validation status would not be *Met*. Likewise, if the PIP did not demonstrate statistically significant improvement across all study indicator rates, from baseline to remeasurement, the critical evaluation element in Activity IX would not receive a *Met* score and the overall validation status would not be *Met*. Additionally, those PIPs that demonstrated statistically significant improvement over baseline at the first remeasurement for last year's validation progressed to Activity X, and they were evaluated on an additional critical element for the first time in this year's validation. For those PIPs that progressed to Activity X, if the second remeasurement results did not demonstrate sustained improvement over baseline across all study indicators, the critical evaluation element in Activity X would not receive a *Met* score and the overall validation status would not be Met.

Figure 6-3 displays the percentage of state-mandated PIPs receiving a Met, Partially Met, and Not Met overall validation status by plan type and PIP topic for the SFY 2017–2018 validation cycle. Thirty-one of the 76 PIPs validated focused on one of the three state-mandated topics. The green bars represent the percentage of PIPs with an overall validation status of *Met*, the blue bars represent the percentage of PIPs with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

Figure 6-3—Overall Validation Status of State-Mandated PIPs by PIP Topic



	Prenatal Care and Well-Child Visits	Preventive Dental Services for Children	Medication Review	OVERALL TOTAL
Percentage of PIPs with Met Status	9%	64%	50%	42%
Percentage of PIPs with Partially Met Status	82%	36%	33%	52%
Percentage of PIPs with Not Met Status	9%	0%	17%	6%

Across all state-mandated PIPs, 42 percent received an overall *Met* validation status, 52 percent received an overall *Partially Met* validation status, and 6 percent received a *Not Met* validation status. The percentage of PIPs receiving a *Met* validation status was highest for the *Preventive Dental Services for Children* PIPs (64 percent). The second-highest percentage (50 percent) of PIPs receiving a *Met* validation status was among the *Medication Review* PIPs. The *Improving Timeliness of Prenatal Care*

and Well-Child Visits in the First 15 Months of Life—Six or More Visits PIPs had the lowest percentage, with only 9 percent of the PIPs receiving an overall *Met* validation status. Most of the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIPs (82 percent) received a *Partially Met* validation status, suggesting that the PIPs addressed some but not all critical evaluation elements included in HSAG's PIP validation methodology.

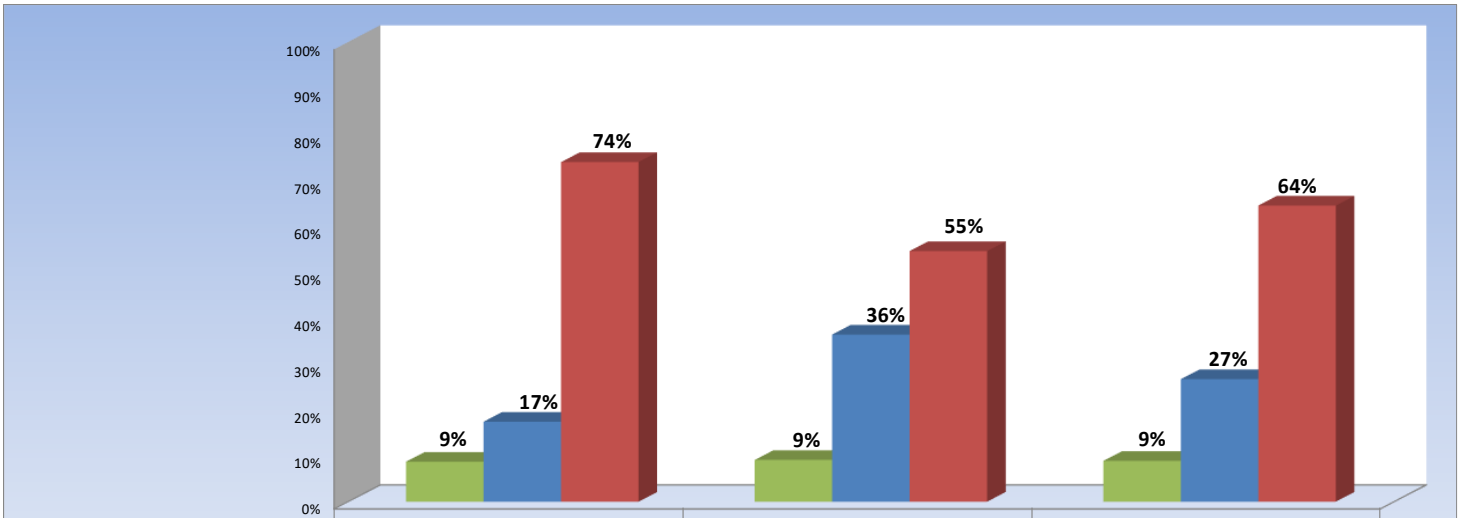
The state-mandated PIPs had progressed through Activity IX or X of the Outcomes stage for this year's validation; therefore, validation status was based on the study design of the PIP, the data analysis and quality improvement (QI) activities conducted for the current period, and whether statistically significant improvement was demonstrated by the study indicator results. For those PIPs that progressed to Activity X, the validation status was also based on whether study indicator outcomes demonstrated sustained improvement at Remeasurement 2. In general, the PIPs were well-designed; however, opportunities for improvement exist with data reporting and statistical analysis, QI activities and intervention evaluation, and achieving statistically significant improvement over the baseline. Across the state-mandated PIP topics, the three common reasons that plans did not receive a *Met* validation status in last year's validation persisted for this year's validation.

- Incorrect or incomplete reporting of study indicator or statistical testing results
- Lack of processes for evaluating the effectiveness for each intervention
- Not receiving a *Met* score for at least 80 percent of all applicable evaluation elements validated across all PIPs

Also, as in last year's validation results, for the *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* PIP, some plans did not achieve statistically significant improvement over the baseline across all study indicators, which resulted in an overall *Partially Met* or *Not Met* validation status. Plans may improve the validation status and the quality of their PIPs in the following ways: addressing HSAG's feedback in the PIP validation tools and ensuring that all data and statistical testing outcomes are reported accurately; appropriately evaluating each intervention for effectiveness; and investigating and addressing the root cause for not achieving the desired outcomes for the study indicators with active, innovative interventions and improvement strategies. Plans can also request technical assistance (TA) from HSAG to address questions related to the PIP methodology and QI tools and processes.

In addition to the 31 state-mandated PIPs represented in Figure 6-3, HSAG validated 23 plan-selected clinical PIPs and 22 plan-selected nonclinical PIPs. Figure 6-4 displays the percentage of clinical and nonclinical PIPs receiving a *Met, Partially Met,* and *Not Met* overall validation status for the SFY 2017–2018 validation cycle. The green bars represent the percentage of PIPs with an overall validation status of *Met*, the blue bars represent the percentage of PIPs with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

Figure 6-4—Overall Validation Status of Plan-Selected Clinical and Nonclinical PIPs

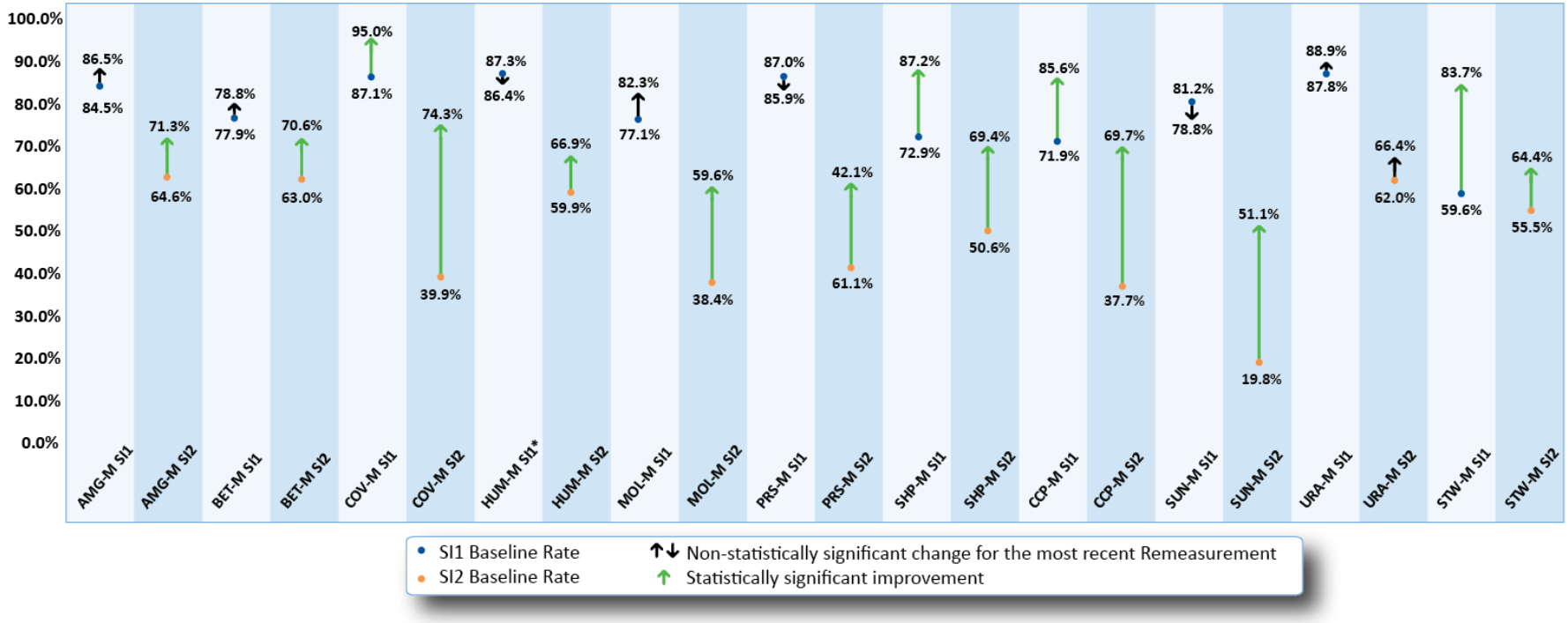


	Clinical PIPs	Nonclinical PIPs	OVERALL TOTAL
Percentage of PIPs with Met Status	9%	9%	9%
Percentage of PIPs with Partially Met Status	17%	36%	27%
Percentage of PIPs with Not Met Status	74%	55%	64%

The validation results for the plan-selected PIPs demonstrate that the plans continue to have room for improvement in addressing HSAG's evaluation requirements for receiving a *Met* validation status. An equal percentage of clinical and nonclinical PIPs (9 percent) received a *Met* validation status. A smaller percentage of clinical PIPs (17 percent) than nonclinical PIPs (36 percent) received a *Partially Met* validation status. For both clinical and nonclinical PIPs, the most common validation status was *Not Met*, with 74 percent of clinical PIPs, 55 percent of nonclinical PIPs, and 64 percent of plan-selected PIPs overall receiving a *Not Met* validation status. The results suggest that most of the plan-selected clinical and nonclinical PIPs did not address all HSAG's PIP validation requirements.

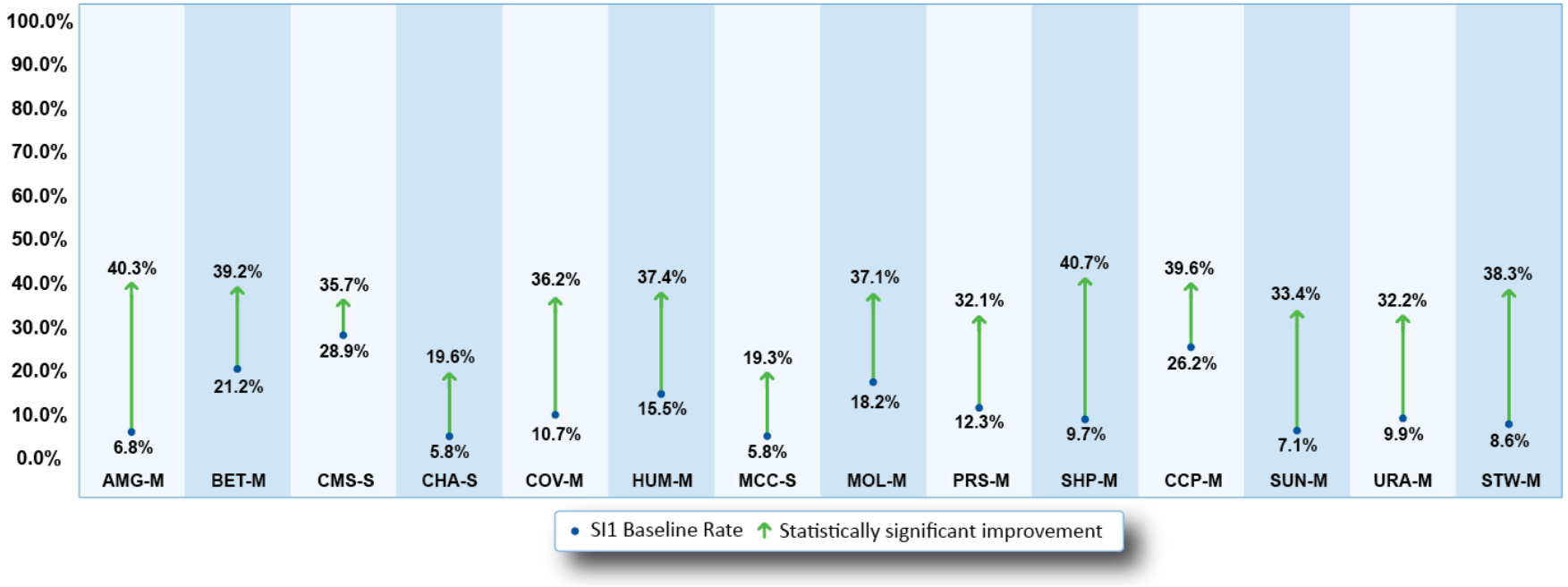
The overall percentage of plan-selected clinical and nonclinical PIPs that received a *Met* validation status (9 percent) was lower than the overall percentage of state-mandated PIP topics that received a *Met* validation status (42 percent, Figure 6-3). This comparison suggests that the plans have more room for improvement in the plan-selected PIPs than in the state-mandated PIPs; however, for the plan-selected PIPs the common reasons for not receiving a *Met* validation status were the same as those noted above for the state-mandated PIPs. The plans have room for improvement in the QI processes and activities used for the PIPs. The plans should address deficiencies in the Implementation stage related to data analysis, interpretation of results, and intervention evaluation, to provide a solid foundation for achieving improvement in the study indicator rates at the second remeasurement. The plans have access to HSAG's feedback as well as guidance in the PIP validation tools and the PIP completion instructions, and they may seek TA from HSAG, as needed, to address any identified issues.

Figure 6-5—State-Mandated *Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits* Study Indicator Results for SFY 2017–2018*



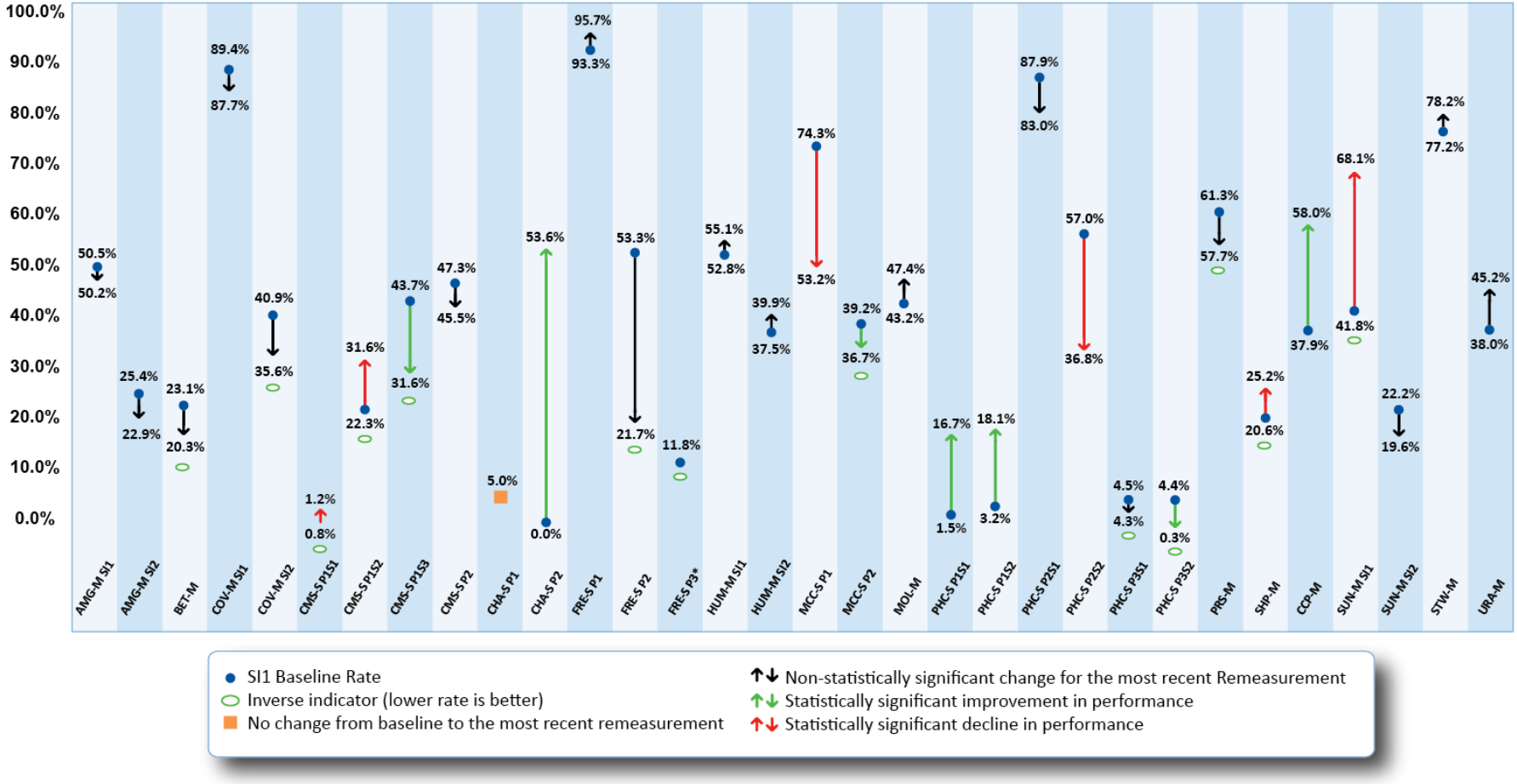
* The plan study indicator labels on the x axis have been abbreviated to the four-letter code to accommodate all the data points.

Figure 6-6—State-Mandated *Preventive Dental Services for Children* Study Indicator Results for SFY 2017–2018*



* The plan study indicator labels on the x axis have been abbreviated to the four-letter code to accommodate all the data points.

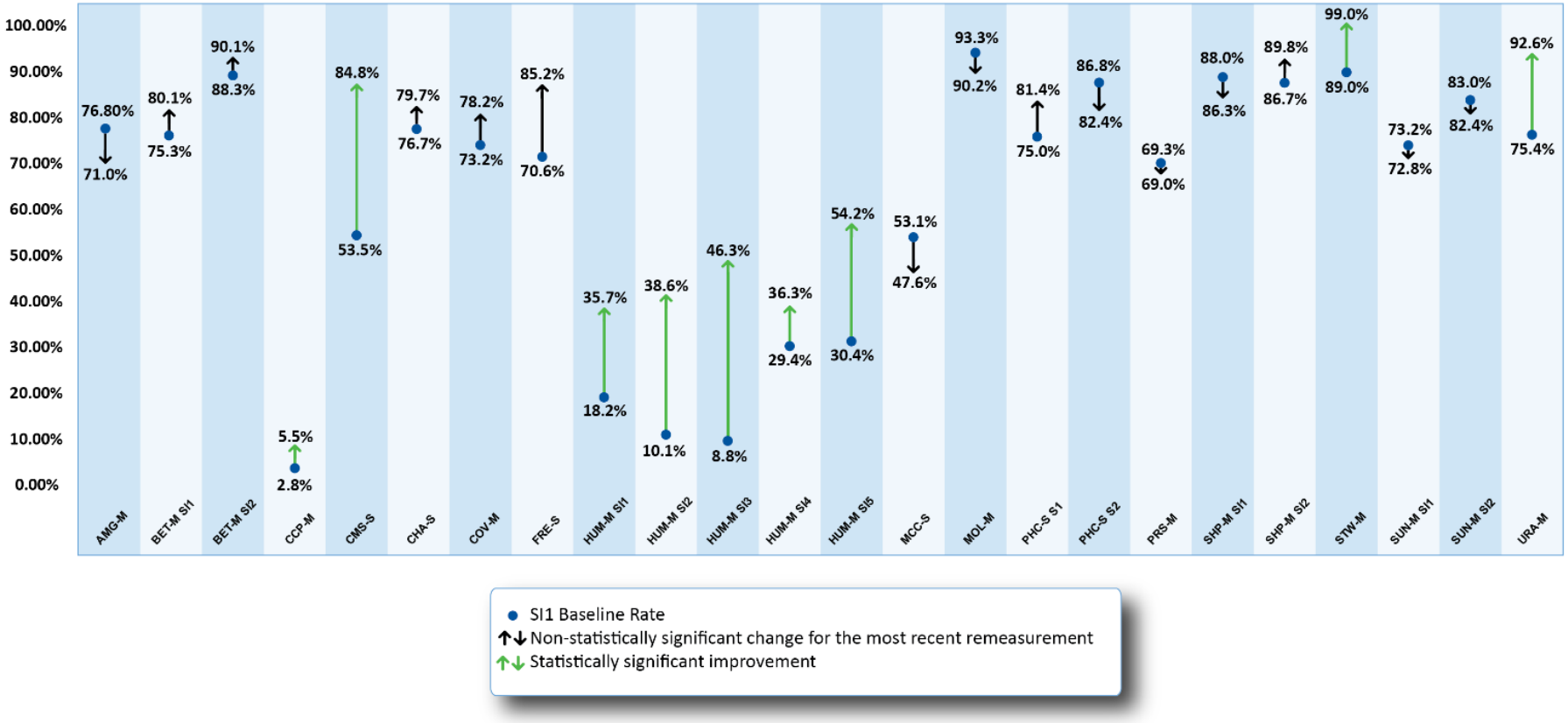
Figure 6-7—Clinical PIP Study Indicator Results for SFY 2017–2018 for MMA Plans**



* The plan did not progress to reporting remeasurement results for the current validation cycle.

** The plan study indicator labels on the x axis have been abbreviated to the four-letter code to accommodate all the data points.

Figure 6-8—Nonclinical PIP Study Indicator Results for SFY 2017–2018 for MMA Plans*



* The plan study indicator labels on the x axis have been abbreviated to the four-letter code to accommodate all the data points.

Recommendations

Based on the validation results across all PIPs, HSAG made observations about the design and implementation of the PIPs during the baseline measurement period. HSAG offers the following recommendations related to the validation scores to improve the structure and implementation of the PIPs as well as to support progress toward improved PIP outcomes in the future.

Overall recommendations:

- AHCA should continue to explore and identify innovative interventions and share intervention examples with the plans. Sharing potentially promising strategies with the plans may help facilitate improvement in individual PIPs and in statewide efforts.
- The plans should conduct accurate data analyses of study indicator results and appropriate statistical testing between each study indicator remeasurement rate and the baseline rate to evaluate PIP progress toward achieving and sustaining statistically significant improvement in study indicator outcomes.
- The plans should use active, innovative improvement strategies that have the potential to directly and positively impact study indicator outcomes for each PIP.
- The plans should have a methodologically robust process in place for evaluating the effectiveness of each intervention and its impact on the study indicators and should use intervention-specific evaluation results to guide next steps of each intervention.

7. Overall Assessment of Progress in Meeting EQRO Recommendations

During previous years, HSAG made recommendations in the annual reports for each of the activities that were conducted. Table 7-1 is a summary of the follow-up actions per activity that AHCA completed in response to HSAG's recommendations during SFY 2016–2017.

Table 7-1—**HSAG Recommendations With AHCA Actions**

HSAG Recommendation	AHCA Action
Performance Improvement Projects	
AHCA should continue the PIP check-in process with each plan. This process helps AHCA more closely monitor each plan's PIP progress and identify opportunities for training and TA. AHCA can refer plans to HSAG for more timely TA, as needed, based on the results of the PIP check-in meetings.	AHCA's PIP Check-in Teams held quarterly meetings with each of the plans throughout the year. AHCA staff asked plans to describe which QI processes and tools they were using and encouraged plans to reach out to HSAG's PIP team and to AHCA for additional TA as needed. HSAG's PIP team provided TA throughout the year to enhance the plans' capacity to implement robust QI processes and strategies for their PIPs. AHCA plans to continue the PIP check-in process.
Continue to explore and identify innovative interventions and share intervention examples with the plans. Sharing potentially promising strategies with the plans may help facilitate improvement in individual PIPs and in statewide efforts.	AHCA staff members continue to compile information on promising interventions to share with the plans. AHCA considers this recommendation completed, as exploring and identifying innovative interventions and sharing interventions are part of regular operations.
Continue to offer and facilitate training and support opportunities to enhance the plans' capacity to implement robust QI processes and strategies for their PIPs. Increasing the plans' efficacy with QI tools such as Plan-Do-Study-Act (PDSA) cycles, especially related to evaluating and refining interventions, should help remove barriers to effectively evaluating improvement strategies and successfully achieving improvement in the PIP study indicators.	AHCA staff members discussed QI processes with the plans during PIP check-in calls during the year. AHCA and HSAG consider this recommendation ongoing.
Validation of Performance Measures	
MMA Plans: During the PMV process, HSAG identified an opportunity to improve clarification	AHCA shared HSAG's feedback with CMS on 3/15/17, and CMS responded that it would share

HSAG Recommendation	AHCA Action
of specifications for the *Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk* measure. During the review, HSAG noted that most MMA plans' eligible population values for this measure were identical to the denominator values. However, two plans' eligible populations were greater than the denominators. One potential reason for the differences in values could be related to the timing of when plans applied the exclusionary criteria (e.g., applying exclusions before the eligible population is identified). The specifications do not seem to clearly define the criteria that should be used to identify the eligible population for this measure (only the denominator), so it is unclear if the eligible population and denominator values should be equivalent. Further, in the rate reporting template it appears acceptable for plans to report denominator values that are less than the total eligible populations. HSAG recommends that AHCA provide clear guidance for the identification of eligible population in both the reporting requirements and template to unify reporting requirements across all participating plans for the next reporting period.	the feedback with the measure steward. This is a Child Core Set measure, and AHCA is not responsible for updating the specifications for this measure. AHCA and HSAG consider this recommendation closed.
LTC Plans: HSAG recommends that improvement efforts be focused on the *Call Answer Timeliness* measure as it represents the sole opportunity for improvement relative to an AHCA-defined performance target for the LTC plans. In addition, HSAG recommends that improvement efforts be focused on measures with notable performance declines from 2015 to 2016 or measures for which rates with less than 100 percent are deemed noncompliant by AHCA. HSAG's recommended measures for targeted QI activities are as follows: • Case Manager Training • Care for Older Adults—Advance Care Planning—18–60 Years, 61–65 Years, 66+ Years, and Total • Required Record Documentation	AHCA is continuing to monitor plan performance on LTC performance measures. All of the rates for the referenced measures have improved from CY 2015 to 2016, with many rates significantly improving. AHCA considers this recommendation part of regular operations. AHCA and HSAG consider this recommendation closed.
HSAG identified an opportunity to improve the clarification of specifications for the *Timeliness of Services* measure. During the review, HSAG noted that most LTC plans' eligible population	AHCA revised the LTC technical specifications to clarify that exclusions should be applied prior to identifying the eligible population. The revised specifications were posted online in July 2018.

HSAG Recommendation	AHCA Action
values for this measure were identical to the denominator values. However, two plans' eligible populations were substantially greater than the denominators. Although for this measure it is acceptable to report varying eligible populations and denominators, the difference between the two values for these plans seemed questionable. One potential reason for the vast differences in values for these two plans could be related to when plans applied the exclusionary criteria (e.g., applying exclusions after the eligible population is identified). The specifications do not clarify when enrollees (1) who reside in an assisted living facility (ALF), nursing home facility, participant direction option (PDO), or inpatient setting, or (2) who have refused services should be excluded (i.e., whether or not such should be excluded from the eligible population and denominator). HSAG recommends that AHCA provide clear guidance for the identification of the eligible population in the reporting requirements to unify these requirements across all participating plans for the next reporting period.	AHCA and HSAG consider this recommendation closed.
MMA Plans: For performance targets in RY 2017, 42 statewide MMA measure rates fell below AHCA's performance targets. While opportunities for improvement exist in almost all domains of care, HSAG recommends that improvement efforts be focused on measures with 2017 rates falling below AHCA's performance targets by at least 10 percentage points, including the following: • *Pediatric Care* • *Lead Screening in Children* • *Immunizations for Adolescents—Combination 1(Meningococcal, Tdap)* • *Annual Dental Visit—Total* • *Women's Care* • *Breast Cancer Screening* • *Living With Illness* • *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total*	AHCA continues to monitor plan performance on all MMA performance measures. During Quarter 3, AHCA required plans performing below the Medicaid 50th percentile for the *Lead Screening* and *Annual Dental Visit* measures to submit action plans for improvement, and AHCA staff reviewed the plans' action plans and provided feedback. AHCA considers this recommendation part of regular operations.

HSAG Recommendation	AHCA Action
• *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total* • *Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total* • *Behavioral Health* • *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* • *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* • *Access/Availability of Care* • *Adults' Access to Preventive/Ambulatory Health Services—Total*	
MMA Plans: HSAG recommends that improvement efforts be focused on measures with notable rate declines (more than 10 percentage points) from RY 2016 to 2017, including the following: Living With Illness • Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—18–64 Years of Age, 65+ Years of Age, and Total • Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—18–64 Years of Age, 65+ Years of Age, and Total • Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—18–64 Years of Age, 65+ Years of Age, and Total	AHCA continues to monitor plan performance on all performance measures and considers this part of regular operations.
HSAG recommends that MMA plans develop improvement strategies to target the measures listed above. For example, MMA plans could investigate root causes associated with low performance based on the care provided to children and thereby target improvement activities that could increase compliance on numerous indicators of care such as *Immunizations for Adolescents*.	AHCA monitors plan performance on all performance measures. Plans develop improvement strategies and describe them generally in the QI plans as well as more specifically in their PIPs and action plans. AHCA considers this part of regular operations.

HSAG Recommendation	AHCA Action
LTC Plans: Based on a review of the Final Audit Reports (FARs), HSAG found that all LTC plans' audits were conducted based on NCQA HEDIS Compliance Audit policies and procedures. As such, findings pertaining to the different data systems and process used to calculate and report the AHCA-defined performance measures, including the case management system, were not included in the reports. Since some of the measures rely on data that are collected outside the usual data systems included in a typical NCQA HEDIS Compliance Audit, HSAG recommends that AHCA require the FARs to include a brief description of the data systems and a brief summary of the activities conducted by the plans in response to the findings from the previous year's audit used for calculating AHCA-defined measures.	AHCA has this recommendation under consideration.
LTC Plans: HSAG recommends that improvement efforts be focused on measure rates with notable performance declines (i.e., a decrease of 10 or more percentage points) from 2016 to 2017. The only statewide weighted average that demonstrated a decline of at least 10 percentage points from RY 2016 (90.23 percent) to 2017 (76.41 percent) was the *Face-to-Face Encounters* measure.	AHCA continues to monitor plan performance on all performance measures. During the appeals process for performance measure liquidated damages (LDs), two LTC plans determined that they did not correctly calculate the *Face-to-Face Encounters* measure. The two plans re-ran the measure and submitted audited results to AHCA in March. The CY 2016 statewide average is 91.98 percent, so there was not a decline. AHCA and HSAG consider this recommendation closed.
LTC Plans: For RY 2017, the *Face-to-Face Encounters* measure was the only statewide weighted average that demonstrated a decline of more than 10 percentage points, indicating an opportunity to investigate and address the decline in performance, and increase the number of face-to-face encounters with case/care managers for enrollees.	AHCA continues to monitor plan performance on all performance measures. During the appeals process for performance measure LDs, two LTC plans determined that they did not correctly calculate the *Face-to-Face Encounters* measure. The two plans re-ran the measure and submitted audited results to AHCA in March. The CY 2016 statewide average is 91.98 percent, so there was not a decline. AHCA and HSAG consider this recommendation closed.
LTC Plans: HSAG recommends that LTC plans conduct a root cause analysis of measure indicators that have been identified as areas of low performance to determine the nature and scope of problems, identify causes and their interrelationships, identify specific populations for targeted interventions, and establish potential	AHCA continues to monitor plan performance measures and considers this part of regular operations.

HSAG Recommendation	AHCA Action
performance improvement strategies and solutions.	
LTC Plans: Although some improvement was demonstrated in the *Case Manager Training* measure among the LTC plans, no LTC plan reported a rate of 100 percent for this measure. LTC plans with less than 100 percent performance should investigate the root cause of the noncompliance and assure proper, timely training on the mandate to report abuse, neglect, and exploitation for their case managers. Similarly, the *Required Record Documentation* measure assesses the percentage of enrollees whose records contained specific documents to be maintained by the LTC plans; therefore, a rate less than 100 percent would imply noncompliance with AHCA's expectation.	AHCA mandates that plans are responsible for ensuring their case managers receive training and plans may be subject to LDs for deficiencies. AHCA considers this part of regular operations.
LTC Plans: Focus improvement efforts on measures with notable performance declines from RY 2016 to RY 2017 (i.e., a decrease of 10 or more percentage points) or measures for which rates with less than 100 percent are deemed noncompliant by AHCA. HSAG's recommended measures for targeted QI activities are as follows: • *Case Manager Training* • *Required Record Documentation* • *Face-to-Face Encounters*	AHCA monitors plan performance on all performance measures. Plans develop improvement strategies and describe them generally in the QI plans as well as more specifically in their PIPs. AHCA considers this part of regular operations.
Compliance With Access, Structure, and Operations Standards	
AHCA should establish a consistent methodology when conducting periodic monitoring, and review activities to be consistent with EQR protocols to provide a uniform method of ensuring that federal and state requirements for managed care programs are met by the plans. The reviews must be comparable to the standards for EQR-related activities and consistent with the EQR protocol in accordance with §438.452.	AHCA began strategic planning for how to conduct a comprehensive three-year compliance review according to the federal standards. As a part of planning, AHCA requested a cost estimate from its EQRO to complete the following tasks related to compliance reviews: (1) development of a compliance review tool to include federal and state contract standards; (2) desk reviews of the evidence of compliance provided by the plans; (3) on-site visits to the plans, including interviews with staff and document review; (4) generating preliminary reports of the results of the compliance review using the compliance review tool; and (5) developing full reports of the results of the compliance review in a report format.

HSAG Recommendation	AHCA Action
AHCA should establish a consistent methodology using standard scoring to establish the threshold for compliance and score the plans as fully compliant only when all elements of the standard are present. AHCA should conduct a scheduled and complete review of activities and standards as required under 438 Subpart E. Conducting an organized and methodical compliance review will assist AHCA to not only determine performance and compliance but to identify failures in systems and to correct these in a timely manner.	AHCA began strategic planning for how to conduct a comprehensive three-year compliance review according to the federal standards. As a part of planning, AHCA requested a cost estimate from its EQRO to complete the following tasks related to compliance reviews: (1) development of a compliance review tool to include federal and state contract standards; (2) desk reviews of the evidence of compliance provided by the plans; (3) on-site visits to the plans, including interviews with staff and document review; (4) generating preliminary reports of the results of the compliance review using the compliance review tool; and (5) developing full reports of the results of the compliance review in a report format.
Develop a standardized tool to allow multiple AHCA groups to document compliance with an established threshold and determine the plans as fully compliant only when all elements of the standard are present.	AHCA began strategic planning for how to conduct a comprehensive three-year compliance review according to the federal standards. As a part of planning, AHCA requested a cost estimate from its EQRO to complete the following tasks related to compliance reviews: (1) development of a compliance review tool to include federal and state contract standards; (2) desk reviews of the evidence of compliance provided by the plans; (3) on-site visits to the plans, including interviews with staff and document review; (4) generating preliminary reports of the results of the compliance review using the compliance review tool; and (5) developing full reports of the results of the compliance review in a report format.
AHCA should determine which plans and which standard categories need more TA to improve performance, based on information from the compliance review and monitoring that occurs throughout the year.	AHCA began strategic planning for how to conduct a comprehensive three-year compliance review according to the federal standards. As a part of planning, AHCA requested a cost estimate from its EQRO to complete the following tasks related to compliance reviews: (1) development of a compliance review tool to include federal and state contract standards; (2) desk reviews of the evidence of compliance provided by the plans; (3) on-site visits to the plans, including interviews with staff and document review; (4) generating preliminary reports of the results of the compliance review using the compliance review tool; and (5) developing full reports of the results of the compliance review in a report format.

HSAG Recommendation	AHCA Action
AHCA's compliance review should consist of a desk and on-site review, both of which encompass a review of documents to ensure that the policies and procedures submitted in the desk review are operationalized at the plan level. In addition, the on-site review should include interviews with key staff members to collect data to supplement and verify what was learned in the preliminary document review and on-site document review.	AHCA began strategic planning for how to conduct a comprehensive three-year compliance review according to the federal standards. As a part of planning, AHCA requested a cost estimate from its EQRO to complete the following tasks related to compliance reviews: (1) development of a compliance review tool to include federal and state contract standards; (2) desk reviews of the evidence of compliance provided by the plans; (3) on-site visits to the plans, including interviews with staff and document review; (4) generating preliminary reports of the results of the compliance review using the compliance review tool; and (5) developing full reports of the results of the compliance review in a report format.
Produce a summary document that details the plans' noncompliance with contract requirements and/or federal standards.	AHCA began strategic planning for how to conduct a comprehensive three-year compliance review according to the federal standards. As a part of planning, AHCA requested a cost estimate from its EQRO to complete the following tasks related to compliance reviews: (1) development of a compliance review tool to include federal and state contract standards; (2) desk reviews of the evidence of compliance provided by the plans; (3) on-site visits to the plans, including interviews with staff and document review; (4) generating preliminary reports of the results of the compliance review using the compliance review tool; and (5) developing full reports of the results of the compliance review in a report format.
Validation of Encounter Data from Contract Year 4	
AHCA should continue to work with Florida's Medicaid Management Information System (FMMIS) and Decision Support System (DSS) teams to review quality control procedures to ensure accurate production of data extracts. Through the development of standard data extraction procedures, quality controls, and process documentation, the number of errors associated with extracted data could be reduced, leading to more accurate data extractions and reporting. Moreover, the development and implementation of stored procedures can be reused for similar activities with minimal changes for future studies. Sufficient processes and	AHCA continually looks for ways to improve the quality of its inbound encounter data and will take these suggestions under advisement. AHCA considers this recommendation to be part of regular operations.

HSAG Recommendation	AHCA Action
training should also be put in place to ensure the data are thoroughly validated for accuracy and completeness prior to submission and delivery. HSAG recommends that AHCA's data quality checks include, but not be limited to, the following: • Data were extracted according to the data submission requirements document. • Control totals for each of the requested data files are reasonable. • Determine if duplicate records are reasonable. • Distributions of the data field values are reasonable. • Presence check; i.e., data with missing values for all records in any of the data fields. • Data fields were populated with reasonable values. The validity of data submitted for evaluation has been a consistent issue impacting reporting for several encounter data evaluation studies. HSAG recommends that AHCA convene a time-limited, post-study workgroup to identify, evaluate, and propose solutions to address ongoing quality issues. Processes to be reviewed include the communication of extraction requirements, identification of extracted fields, and defined quality control steps and processes.	
AHCA should work with the FMMIS vendor to develop supplemental encounter data submission guidelines, and/or expand its existing Companion Guide to clearly define appropriate submission requirements for nonstandard data elements necessary for data processing (e.g., Payer Responsibility Sequence Code). Ensuring that plans submit data elements consistently and in alignment with FMMIS processing rules is critical to being able to report and process encounter data for reporting. Once guidelines are established, TA calls/meetings can be scheduled to make sure all parties understand any new submission requirements. Additionally, AHCA should work with its FMMIS and DSS data vendors to develop internal data processing routines to establish standardized	AHCA staff continue to work with the MMIS vendor to improve the collection of encounter data from the plans. AHCA considers this recommendation part of regular operations. AHCA and HSAG consider this recommendation closed.

HSAG Recommendation	AHCA Action
programming logic to ensure plan encounter data are accurately processed.	
AHCA should review, and modify as needed, existing plan contracts to include language outlining specific requirements for submitting valid clinical record documentation (i.e., medical records, plans of care, and treatment plans) to AHCA or its representatives, in addition to defining the requirements and submission standards for the procurement of requested clinical records. To allow for proper oversight of clinical services and care management activities, it is important to build expectations directly into contracts regarding the submission of supporting documentation. Moreover, HSAG recommends including language that allows AHCA to hold plans accountable for meeting submission expectations. Additionally, to ensure clinical documentation is complete and valid, modifications to the contract should include language that outlines minimum documentation requirements and expected templates for plans of care/treatment plans. Including this information ensures the availability to information critical to oversight activities.	In the new contracts with the plans, AHCA has included LDs related to cooperating with the EQRO and responding to AHCA's requests for documentation that can be used in these instances. AHCA and HSAG consider this recommendation closed.
AHCA should continue to collaborate with the plans to monitor, investigate, and reconcile discrepancies in encounter data volume regularly. Although encounter data volume trends were similar between AHCA- and plan-submitted encounter data, differences in overall volume suggest potential deficiencies in the data. Results from the current study should be used to target specific encounter data to conduct data mining reviews and determine whether differences were due to failed or incomplete submissions or processing parameters associated with FMMIS.	AHCA is reviewing the analysis comparing the data submitted as encounters through FMMIS and DSS with files submitted directly to Medicaid Data Analytics. AHCA staff have been conducting preliminary analyses comparing encounters submitted through FMMIS to those submitted directly to Data Analytics. AHCA staff also monitor encounter submissions for timeliness and accuracy. AHCA considers this part of regular operations.
AHCA should continue to work with the plans and monitor the submission of the Plan Provider ID field to ensure the accuracy of the submitted field. Additionally, while AHCA noted that edits are in place, the implementation of the edits should be consistently applied and reported.	AHCA continues to use the Plan Provider ID in the ISA02 segment in the header envelope of the 837 transactions to verify submissions. Any invalid or missing Plan Provider IDs will result in an error code of 1011 and is set to deny for all encounters. AHCA and HSAG consider this recommendation closed.

HSAG Recommendation	AHCA Action
AHCA should work with its MMIS data vendor to develop a standardized process to track and identify the final adjudication record of an encounter. AHCA and its data vendor should develop an algorithm that is in alignment with the assignment of the identification numbers according to the type of encounter transaction and how the encounter was received. AHCA should also consider enhancing current submission requirements to ensure adjusted encounters are submitted appropriately to better identify the final status records in AHCA's encounter data.	AHCA continues to explore ways to improve its auditing capabilities to track the "latest" encounter in a string of voids, adjustments, and resubmissions.
While plans are required to submit the National Provider Identifier (NPI), the provider Medicaid ID should only be submitted by non-healthcare providers who cannot obtain an NPI. AHCA should work with the plans in ensuring accurate processing of provider information within the plans' systems.	AHCA continues to improve its collection, validation, and use of the NPI. Because not all provider types are required to have an NPI but are required to have a Medicaid ID to bill Florida Medicaid, AHCA will continue to require that plans submit the Medicaid ID where deemed appropriate. AHCA and HSAG consider this recommendation closed.

Appendix A. Plan Names/Abbreviations

SFY 2017–2018 Plan-Approved Naming Convention

Full Plan Name	4-Letter Code	Shortened Name
MMA Plans		
Amerigroup Community Care	AMG-M	Amerigroup
Better Health	BET-M	Better Health
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	COV-M	Aetna Better Health
Humana Medical Plan, Inc.	HUM-M	Humana
Molina Healthcare of Florida, Inc.	MOL-M	Molina
Prestige Health Choice	PRS-M	Prestige
South Florida Community Care Network, d/b/a Community Care Plan	CCP-M	Community Care Plan
Simply Healthcare Plans, Inc.	SHP-M	Simply
Sunshine State Health Plan, Inc.	SUN-M	Sunshine
UnitedHealthcare of Florida, Inc.	URA-M	United
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	STW-M	Staywell
Specialty Plans		
AHF MCO of Florida, Inc. d/b/a Positive Healthcare, Inc.	PHC-S	Positive-S
Children's Medical Services Network	CMS-S	Children's Medical Services-S
Clear Health Alliance	CHA-S	Clear Health-S
Freedom Health, Inc.	FRE-S	Freedom-S
Magellan Complete Care	MCC-S	Magellan-S
Sunshine State Health Plan, Inc.	SUN-S	Sunshine-S
Long-Term Care Plans		
Amerigroup Community Care	AMG-L	Amerigroup-LTC
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	COV-L	Aetna Better Health-LTC
Humana Medical Plan, Inc.	HUM-L	Humana-LTC
Molina Healthcare of Florida, Inc.	MOL-L	Molina-LTC
Sunshine State Health Plan, Inc.	SUN-L	Sunshine-LTC
UnitedHealthcare of Florida, Inc.	URA-L	United-LTC

Appendix B. MCO PIP Validation Results

Table B-1 includes the following information for each MMA plan's PIP topic and corresponding validation scores and status. In the Validation Scores and Status column, the validation results for each PIP are listed in order from left to right, separated by slash marks: percentage of all evaluation elements receiving a *Met* score, percentage of critical elements receiving a *Met* score, and overall validation status.

Table B-1—MMA Plans

Plan Name	PIP Topic	Validation Scores and Status
AHF MCO of Florida, Inc., d/b/a Positive Healthcare, Inc.	*7- and 30-Day Follow-up After a Hospitalization for a Mental Illness*	*100% / 100% / Met*
	Improving Rates of CD4 and Viral Load Testing	*90% /90% / Not Met*
	Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDS	*82% / 77% / Not Met*
	Reducing Avoidable Emergency Room Visits	*86% / 90% / Partially Met*
Amerigroup Community Care	*Improving Overall Member Satisfaction*	*85% / 85% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*89% / 85% / Partially Met*
	Improving Medication Management for People with Asthma	*80% / 80% / Not Met*
	Preventive Dental Services for Children	*95% / 100% / Met*
Better Health	*Improve Member Satisfaction*	*85% / 83% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*86% / 85% / Partially Met*
	Preventive Dental Services for Children	*95% / 100% / Met*
	Reduce All-Cause Hospital Readmissions Within 30 Days	*80% / 80% / Not Met*

Plan Name	PIP Topic	Validation Scores and Status
Children's Medical Services Network	*Decreasing Behavioral Health Readmission Rates*	*68% / 58% / Not Met*
	Improving Call Center Timeliness	*70% / 80% /Partially Met*
	Preventive Dental Services for Children	*81% / 91% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*80% / 80% / Not Met*
Clear Health Alliance	*Behavioral Health Screening of CHA Members by a PCP*	*82% / 82% / Not Met*
	Improve Member Satisfaction	*88% / 83% / Not Met*
	Improving the Percentage of Enrollees Receiving 2 or More HIV-Related Outpatient Medical Visits at Least 182 Days Apart	*86% / 100% / Met*
	Preventive Dental Services for Children	*86% / 91% / Partially Met*
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Improving Member Management of Diabetes*	*82% / 85% / Not Met*
	Improving Member Satisfaction	*93% / 92% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
Freedom Health, Inc.	*Care for Older Adults (COA)—Advance Care Planning*	*75% / 73% / Not Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Poor Control > 9%	*77% / 73% / Not Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	*76% / 73% / Not Met*
	Plan All-Cause Readmissions (PCR)	*88% / 89% / Partially Met*
Humana Medical Plan, Inc.	*Electronic Health Record with Meaningful Use*	*76% / 82% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*82% / 77% / Partially Met*
	Integrating Primary Care and Behavioral Health in Antidepressant Medication Management	*85% / 80% / Not Met*

Plan Name	PIP Topic	Validation Scores and Status
	Preventive Dental Services for Children	*95% / 100% / Met*
Magellan Complete Care	*Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*76% / 70% / Not Met*
	Increase the Rate of Adult Member's Overall Satisfaction (CAHPS)	*78% / 75% / Not Met*
	Plan All-Cause Readmissions (PCR)	*80% / 80% / Partially Met*
	Preventive Dental Services for Children	*81% / 91% / Partially Met*
Molina Healthcare of Florida, Inc.	*Improving the Rate of Asthmatic Children Using Controller Medications*	*90% / 90% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*96% / 92% / Partially Met*
	Practitioner Satisfaction	*89% / 85% / Not Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
Prestige Health Choice	*Improve Rates for HbA1c Testing and Compliance Among Diabetics*	*76% / 79% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*79% / 77% / Partially Met*
	Overall Health Plan Rating Via CAHPS® 5.0H Adult Medicaid Survey	*77% / 75% / Not Met*
	Preventive Dental Services for Children	*71% / 73% / Partially Met*
Simply Healthcare Plans, Inc.	*Improve Member Satisfaction*	*88% / 83% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*93% / 93% / Partially Met*
	Preventive Dental Services for Children	*95% / 100% / Met*
	Reduce All-Cause Hospital Readmissions Within 30 Days	*81% / 80% / Not Met*

Plan Name	PIP Topic	Validation Scores and Status
South Florida Community Care Network, d/b/a Community Care Plan	*Improving the Number of Health Risk Assessments*	*86% / 82% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*83% / 86% / Partially Met*
	Increasing the Diabetic Retinal Examination Rate for Enrollees	*80% / 82% / Partially Met*
	Preventive Dental Services for Children	*76% / 73% / Partially Met*
Sunshine State Health Plan, Inc.	*Comprehensive Diabetic Care—Duval County*	*73% / 73% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*75% / 77% / Partially Met*
	Member Satisfaction	*79% / 75% / Partially Met*
	Preventive Dental Services for Children	*95% / 100% / Met*
UnitedHealthcare of Florida, Inc.	*Annual Diabetic Retinal Eye Exam*	*88% / 92% / Not Met*
	Call Answer Timeliness (CAT)	*100% / 100% / Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*93% / 92% / Not Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	*Call Answer Timeliness (CAT)*	*84% / 90% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*79% / 77% / Partially Met*
	Improving Well-Child Visit Rates for Children Residing in Pine Hills Community	*71% / 60% / Not Met*
	Preventive Dental Services for Children	*95% / 100% / Met*

Table B-2 includes the following information for each LTC plan: PIP topic and corresponding validation scores and status. In the Validation Scores and Status column, the validation results for each PIP are listed in order from left to right, separated by slash marks: percentage of all evaluation elements receiving a *Met* score, percentage of critical elements receiving a *Met* score, and overall validation status.

Table B-2—LTC Plans

Plan Name	PIP Topic	Validation Scores and Status
Amerigroup Community Care	*Improving the Number of Members with Advance Directives*	*97% / 100% / Met*
	Medication Review	*100% / 100% / Met*
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Medication Review*	*78% / 80% / Partially Met*
	Timeliness of Services for the Long-Term Care Program	*86% / 90% / Partially Met*
Humana Medical Plan, Inc.	*Person-Centered Care Plan*	*76% / 82% / Partially Met*
	Medication Review	*90% / 100% / Met*
Molina Healthcare of Florida, Inc.	*Medication Review*	*61% / 62% / Not Met*
	Provider Satisfaction	*86% / 85% / Not Met*
Sunshine State Health Plan, Inc.	*Medication Review*	*84% / 90% / Partially Met*
	Timeliness of Services	*75% / 80% / Partially Met*
UnitedHealthcare of Florida, Inc.	*Documentation of an Advance Directive*	*90% / 91% / Not Met*
	Medication Review	*100% / 100% / Met*

Appendix C. PIP Study Indicator Rates

Table C-1—Plan Selected Clinical PIP Study Indicator Rates for MMA Plans

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Improving Member Management of Diabetes*	The percentage of enrollees who had an HbA1c test performed during the measurement year.	89.4%	86.6%	87.7%
		The percentage of enrollees who showed poor glycemic control (HbA1c test result > 9%). ↓	40.9%	41.1%*	35.6%
Amerigroup Community Care	*Improving Medication Management for People with Asthma*	The percentage of enrollees who remained on asthma controller medication for at least 50% of their treatment period.	50.5%	46.3%	50.2%
		The percentage of enrollees who remained on asthma controller medication for at least 75% of their treatment.	25.4%	20.6%	22.9%
Better Health	*Reduce All-Cause Hospital Readmissions Within 30 Days*	The percentage of acute inpatient stays for enrollees during the measurement year that were followed by an acute readmission within 30 days for any diagnosis, for enrollees 0 to 64 years of age. ↓	23.1%	21.9%	20.3%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
South Florida Community Care Network, d/b/a Community Care Plan	*Increase the Diabetic Retinal Examination Rate for Enrollees*	The percentage of enrollees age 18 to 75 with diabetes (type 1 and type 2), assigned to a PCP in one of the targeted cities, who had a diabetic retinal examination performed in the measurement year or had a negative result for a diabetic retinal examination during the year prior to the measurement year.	37.9%	58.0%*	NR

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Children's Medical Services Network	*Decreasing Behavioral Health Readmission Rates*	The rate of children who are admitted to an inpatient facility for a mental or behavioral health issue. ↓	0.8%	1.2%	1.2%
		The rate of children who are readmitted to an inpatient facility (meaning admitted and readmitted during the same period) for a mental or behavioral health issue. ↓	22.3%	36.3%	31.6%
		The rate of children who are readmitted for a mental of behavioral health issue more than twice (meaning admitted and readmitted two or more times during the same period, for a total of three or more admissions) to an inpatient facility. ↓	43.7%	53.0%	31.6%*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	The percentage of enrollees who had six well-child visits by the first 15 months of life.	47.3%	41.8%	45.5%
Clear Health Alliance	*Behavioral Health Screening of CHA Members by a PCP*	The percentage of Clear Health-S enrollees who received an annual behavioral health screen by their PCP.	5.0%	6.2%*	5.0%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
	Improving the Percentage of Enrollees Receiving 2 or More HIV-Related Outpatient Medical Visits at Least 182 Days Apart	The percentage of enrollees diagnosed with HIV/AIDS who were seen on an outpatient basis by a physician, physician assistant, or advanced registered nurse practitioner for two HIV-related medical visits at least 182 days apart within the measurement year.	0.0%	35.2%*	53.6%**
Freedom Health, Inc.	*Comprehensive Diabetes Care (CDC)—HbA1c Poor Control > 9%*	The percentage of plan enrollees 18–75 years of age with a diagnosis of diabetes (Type I and Type II) who had HbA1c poor control > 9% during the measurement year. ↓	53.3%	21.7%	NR
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	The percentage of plan enrollees 18–75 years of age with a diagnosis of diabetes (Type I and Type II) who had HbA1c testing during the measurement year.	93.3%	95.7%	NR
	Plan All-Cause Readmissions (PCR)	The percentage of plan enrollees less than 65 years of age with an unplanned acute readmission for any diagnosis within 30 days of being discharged from an acute inpatient hospital stay. ↓	11.8%	NR	NR
Humana Medical Plan, Inc.	*Integrating Primary Care and Behavioral Health in Antidepressant*	The percentage of eligible enrollees who remained on an antidepressant medication treatment for at least 84 days during the measurement year.	52.8%	54.3%	55.1%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
	Medication Management	The percentage of eligible enrollees who remained on an antidepressant medication treatment for at least 180 days during the measurement year.	37.5%	38.7%	39.9%
Magellan Complete Care	*Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	The percentage of enrollees with schizophrenia or bipolar disorder, using antipsychotic medications, who complete a diabetes screening in Regions 10 and 11.	74.3%	53.2%	NR
	Plan All-Cause Readmissions (PCR)	Percentage of enrollees who had an acute inpatient stay followed by an unplanned acute readmission for any medical or behavioral health diagnosis within 30 days. ↓	39.2%	36.7%*	NR
Molina Healthcare of Florida, Inc.	*Improving the Rate of Asthmatic Children Using Controller Medications*	The percentage of enrollees 5 to 18 years who were identified as having persistent asthma and remained on an asthma controller medication for at least 50 percent of the treatment period.	43.2%	42.7%	47.4%
AHF MCO of Florida, Inc. d/b/a Positive Healthcare, Inc.	*7- and 30-Day Follow-up After a Hospitalization for a Mental Illness*	The percent of acute care facility discharges for enrollees hospitalized for a mental health diagnosis, discharged to the community, and seen on an	1.5%	0.0%	16.7%*

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
		outpatient basis by a mental health practitioner within seven days.			
		The percent of acute care facility discharges for enrollees hospitalized for a mental health diagnosis, discharged to the community, and seen on an outpatient basis by a mental health practitioner within 30 days.	3.2%	0.0%	18.1%*
	Improving Rates of CD4 and Viral Load Testing	The percentage of stable enrollees who get at least two CD4 and viral load (VL) tests during the measurement year.	87.9%	83.6%	83.0%
		The percentage of enrollees with a detectable VL in the previous two years, receiving at least three CD4 and viral load tests during the measurement year.	57.0%	42.9%	36.8%
	Reducing Avoidable Emergency Room Visits	Percentage of avoidable emergency department visits for plan enrollees during the measurement year. ↓	4.5%	3.8%	4.3%
		Percentage of avoidable emergency department visits with ICD 9 [International Classification of Diseases, Ninth Revision] codes selected for persons living with HIV/AIDS. ↓	4.4%	3.3%	0.3%*

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Prestige Health Choice	*Improve Rates for HbA1c Testing and Compliance Among Diabetics*	The percentage of diabetic enrollees 18 to 50 years of age who had an HbA1c test result > 9 or were missing an HbA1c test result within the measurement year. ↓	61.3%	50.8%*	57.7%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Simply Healthcare Plans, Inc.	*Reduce All-Cause Hospital Readmissions Within 30 Days*	The percentage of acute inpatient stays followed by an acute readmission for any diagnosis within 30 days for enrollees 0 to 64 years of age during the measurement year. ↓	20.6%	19.7%	25.2%
Sunshine State Health Plan, Inc.	*Comprehensive Diabetic Care—Duval County*	The percentage of enrollees 18–75 years of age with diabetes, residing in Duval County, who had one or more HbA1c levels of greater than 9 during the measurement year. (inverse indicator) ↓	41.8%	66.6%	68.1%
		The percentage of enrollees 18–75 years of age with diabetes, residing in Duval County, who had one or more LDL-C level of less than 100mg/dl during the measurement year.	22.2%	19.6%	NR
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	*Improving Well-Child Visit Rates for Children Residing in Pine Hills Community*	The percent of children 3–6 years of age residing in Pine Hills Community who had at least one well-child visit with a PCP during the measurement period.	77.2%	76.8%	78.2%
UnitedHealthcare of Florida, Inc.	*Annual Diabetic Retinal Eye Exam*	The percentage of diabetic enrollees 18–75 years of age, residing in Region 4, who had a diabetic retinal eye exam during the measurement year or a	38.0%	50.0%*	45.2%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
		negative result for retinopathy the year prior.			

* The remeasurement rate demonstrated statistically significant improvement over the baseline rate.

** The remeasurement rate demonstrated sustained improvement over the baseline rate.

Note: NR (Not Reported) designates that the plan did not report the study indicator rate during the current validation cycle.

↓ Indicates an inverse indicator, where a lower rate is better.

Table C-2—Plan Selected Nonclinical PIP Study Indicator Rates for MMA Plans

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Improving Member Satisfaction*	The percentage of eligible enrollees who responded with a score of 8 or higher to the overall plan satisfaction CAHPS 5.0 Survey question.	73.2%	77.2%	78.2%
Amerigroup Community Care	*Improving Overall Member Satisfaction*	The percent of enrollees who respond 8, 9, or 10 on Question #35, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"	76.8%	76.8%	71.0%
Better Health	*Improve Member Satisfaction*	The percentage of enrollees who responded to the overall plan satisfaction CAHPS 5.0 Adult survey question with a score of 8 or higher.	75.3%	79.2%	80.1%
		The percentage of enrollees who responded to the overall plan satisfaction CAHPS 5.0 Child survey question with a score of 8 or higher.	88.3%	86.6%	90.1%
Children's Medical Services Network	*Improving Call Center Timeliness*	The percentage of calls received during the measurement year that were answered by a live voice within 30 seconds.	53.5%	54.0%	84.8%*
Clear Health Alliance	*Improve Member Satisfaction*	The percentage of enrollees who responded to the overall plan	76.7%	76.2%	79.7%*

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
		satisfaction CAHPS 5.0 question with a score of 8 or higher.			
South Florida Community Care Network, d/b/a Community Care Plan	*Improving the Number of Health Risk Assessments*	The percentage of returned and completed health risk assessments for new members.	2.8%	5.5%*	5.5%**

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Freedom Health, Inc.	*Care for Older Adults (COA)—Advance Care Planning*	The percentage of enrollees 66 years of age and older as of December 31 of the measurement year who had evidence of advance care planning during the measurement year.	70.6%	85.2%	NR
Humana Medical Plan, Inc.	*Electronic Health Record with Meaningful Use*	The percentage of eligible providers in Region 11 who reported using an Electronic Health Record in a meaningful use manner.	18.2%	23.8%*	35.7%**
		The percentage of eligible providers in Region 10 who reported using an Electronic Health Record in a meaningful use manner.	10.1%	30.1%*	38.6%**
		The percentage of eligible providers in Region 9 who reported using an Electronic Health Record in a meaningful use manner.	8.8%	34.0%*	46.3%**
		The percentage of eligible providers in Region 6 who reported using an Electronic Health Record in a meaningful use manner.	29.4%	24.9%	36.3%*
		The percentage of eligible providers in Region 1 who reported using an Electronic	30.4%	38.4%*	54.2%**

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
		Health Record in a meaningful use manner.			
Magellan Complete Care	*Increase the Rate of Adult Member's Overall Satisfaction (CAHPS)*	The percentage of CAHPS adult survey respondents who respond to the question, "How would you rate your health plan" with a score of 9 or 10.	53.1%	51.0%	47.6%
Molina Healthcare of Florida, Inc.	*Practitioner Satisfaction*	The percentage of practitioners surveyed who responded "very satisfied" or "somewhat satisfied" to overall satisfaction with Molina.	93.3%	91.2%	90.2%
AHF MCO of Florida, Inc. d/b/a Positive Healthcare, Inc.	*Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDS*	The percentage of enrollees who report usually or always receiving health care services in a language they could understand.	75.0%	77.7%	81.4%
		The percentage of enrollees who report usually or always feeling that the health care staff was sensitive to their cultural needs.	86.8%	84.0%	82.4%
Prestige Health Choice	*Overall Health Plan Rating Via CAHPS® 5.0H Adult Medicaid Survey*	The percentage of enrollees that responded to the CAHPS 5.0H Adult Medicaid survey on Rating of Health Plan with a rank of 8, 9, or 10 on a 10-point scale.	69.3%	65.8%	69.0%
	Improve Member Satisfaction	The percentage of adult enrollees who responded with a score of 8 or higher to the overall plan	88.0%	83.7%	86.3%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Simply Healthcare Plans, Inc.		satisfaction CAHPS 5.0 survey question.			
		The percentage of child enrollees who responded with a score of 8 or higher to the overall plan satisfaction CAHPS 5.0 survey question.	86.7%	85.1%	89.8%
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	*Call Answer Timeliness*	The percentage of calls received by the plan's Member Services call center (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.	89.0%	80.7%	99.0%*
Sunshine State Health Plan, Inc.	*Member Satisfaction*	The percentage of enrollees who responded to the CAHPS 5.0 Survey Question 35 with a score of 8 or higher.	73.2%	72.8%	NR
		The percentage of enrollees who responded to the CAHPS 5.0 Survey Question 36 with a score of 8 or higher.	83.0%	82.4%	NR
UnitedHealthcare of Florida, Inc.	*Call Answer Timeliness and Call Abandonment (CAT-CAB)*	The percentage of calls answered by a live voice within 30 seconds.	75.4%	91.6%*	92.6%**

* The remeasurement rate demonstrated statistically significant improvement over the baseline rate.

** The remeasurement rate demonstrated sustained improvement over the baseline rate.

Note: NR (Not Reported) designates that the plan did not report the study indicator rate during the current validation cycle.

Table C-3—Nonclinical PIP Study Indicator Rates for LTC Plans

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Timeliness of Services for the Long-Term Care Program*	The percentage of newly enrolled enrollees who received home health services, adult day care and/or home-delivered meals within 8 business days from the effective date of enrollment.	50.9%	52.8%	81.5%*
		The percentage of newly enrolled enrollees who received home health services within 8 business days from the effective date of enrollment.	62.9%	56.7%	78.2%*
		The percentage of newly enrolled enrollees who received adult day care services within 8 business days from the effective date of enrollment.	54.3%	68.6%*	90.8%*
		The percentage of newly enrolled enrollees who received home-delivered meal services within 8 business days from the effective date of enrollment.	18.7%	36.1%*	80.6%*
Amerigroup Community Care	*Improving the Number of Members with Advance Directives*	The percentage of enrollees who have evidence of advanced care planning in their case records during the measurement year.	73.1%	97.7%*	90.5%**
Humana Medical Plan, Inc.	*Person-centered Care Plan*	The percentage of eligible enrollees that have at least four	53.0%	76.4%*	75.6%**

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
		person-centered care plan updates documented.			
Molina Healthcare of Florida, Inc.	*Provider Satisfaction*	The percent of providers surveyed who responded "satisfied" or "somewhat satisfied" to overall satisfaction with Molina.	87.0%	85.2%	85.1%
Sunshine State Health Plan, Inc.	*Timeliness of Services*	Newly enrolled (eligible) LTC enrollees who receive home health services, or adult day health, or home-delivered meals within 3 calendar days from the effective date of enrollment.	37.2%	32.8%+	55.1%*+
UnitedHealthcare of Florida, Inc.	*Documentation of an Advance Directive*	The percentage of eligible enrollees who complete an Advance Directive during the measurement year.	63.6%	62.6%	59.9%

* The remeasurement rate demonstrated statistically significant improvement over the baseline rate.
** The remeasurement rate demonstrated sustained improvement over the baseline rate.
+ The performance measure rates should be interpreted with caution due to changes in AHCA specifications for the measure.

Appendix D. MCO Performance Measure Results

Appendix D displays plan-specific performance measure results and is organized into sections by domain.

Pediatric Care Domain

Table D-1 shows the performance measure names and associated measure name abbreviations for all measures included in the Pediatric Care domain.

Table D-1—Pediatric Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Well-Child Visits in the First 15 Months of Life—No Well-Child Visits	W15-0
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	W15-6+
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	W34
Childhood Immunization Status—Combination 2	CIS-2
Childhood Immunization Status—Combination 3	CIS-3
Lead Screening in Children	LSC
Follow-Up Care for Children Prescribed Attention-deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase	ADD-I
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	ADD-C
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	WCC
Adolescent Well-Care Visits	AWC
Immunizations for Adolescents—Combination 1	IMA-1
Immunizations for Adolescents—Combination 2	IMA-2
Annual Dental Visit—Total	ADV
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	SEAL

Table D-2 shows the results for the MMA Standard plans and MMA Specialty plans for all measures within the Pediatric Care domain. Please note that Freedom-S and Positive-S were excluded from this table because they were either not required to report any measures within the Pediatric Care domain or they did not have any reportable rates within the Pediatric Care domain.

Table D-2—Pediatric Care Domain Performance Measure Results

Measure	AMG-M	BET-M	CCP-M	CHA-S	CMS-S	COV-M	HUM-M	MCC-S	MOL-M	PRS-M	SHP-M	STW-M	SUN-M	SUN-S	URA-M
W15-0*	1.22%	1.95%	1.69%	NA	0.00%	0.31%	1.22%	NA	2.01%	3.65%	1.46%	1.32%	2.92%	0.97%	2.43%
W15-6+	71.78%	67.40%	72.32%	NA	54.69%	80.69%	73.97%	NA	70.10%	64.23%	70.32%	67.11%	67.40%	63.75%	72.51%
W34	85.40%	77.37%	81.54%	75.93%	73.83%	85.47%	78.83%	58.82%	74.44%	74.70%	83.70%	76.70%	76.16%	85.16%	77.86%
CIS-2	82.48%	73.48%	78.10%	NA	77.13%	80.54%	78.35%	NA	75.43%	77.13%	72.99%	78.35%	77.37%	83.45%	78.83%
CIS-3	77.13%	70.80%	72.51%	NA	72.51%	77.62%	74.21%	NA	72.02%	72.02%	66.42%	72.51%	75.18%	77.62%	73.97%
LSC	73.48%	70.56%	76.40%	NA	62.29%	76.64%	70.07%	NA	62.53%	63.99%	76.16%	64.58%	66.40%	72.85%	67.64%
ADD-I	50.53%	38.11%	41.42%	NA	37.89%	39.37%	38.21%	26.62%	43.69%	50.65%	41.30%	56.69%	46.79%	51.67%	47.28%
ADD-C	67.54%	47.13%	NA	NA	51.90%	50.00%	51.37%	40.91%	60.47%	69.38%	53.06%	71.10%	64.46%	61.54%	64.44%
WCC	89.29%	84.67%	86.13%	80.43%	68.13%	90.30%	89.29%	77.62%	85.54%	85.64%	80.54%	70.88%	86.37%	90.27%	87.59%
AWC	64.48%	57.91%	56.79%	56.58%	59.49%	61.56%	55.21%	42.34%	56.45%	52.31%	65.45%	59.46%	51.58%	64.96%	55.96%
IMA-1	75.91%	75.43%	82.73%	NA	76.89%	74.21%	75.91%	50.85%	67.64%	67.64%	73.97%	70.80%	71.29%	68.86%	71.05%
IMA-2[1]	36.50%	27.01%	33.33%	NA	31.14%	36.74%	35.04%	14.36%	28.71%	32.12%	35.04%	27.98%	26.52%	29.68%	28.95%
ADV	52.34%	55.09%	54.37%	36.76%	52.36%	48.95%	51.93%	34.93%	50.06%	52.34%	54.41%	50.86%	47.52%	63.79%	47.48%
SEAL[2]	27.57%	33.98%	26.12%	NA	20.04%	25.48%	25.00%	0.00%	0.00%	0.00%	29.05%	55.31%	27.89%	31.95%	27.19%

** Indicates that lower rates are better for this measure.*

[1] Due to changes in the technical specifications for this measure, a comparison to benchmarks was not performed; therefore, the rates in the table above are presented for information only.

[2] AHCA did not set a performance target for this measure for RY 2018.

NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.

Freedom-S was not required to report rates on Pediatric Care measures; therefore, the MMA is excluded from the table.

Although Positive-S reported the required Pediatric Care measures, the MMA is excluded from the table due to reporting rates of "NA" for all Pediatric Care measures based on small denominators.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

Women's Care Domain

Table D-3 shows the performance measure names and associated measure name abbreviations for all measures included in the Women's Care domain.

Table D-3—**Women's Care Domain Performance Measure Abbreviations**

Performance Measure	Abbreviation
Cervical Cancer Screening	CCS
Chlamydia Screening in Women—Total	CHL
Breast Cancer Screening	BCS
Prenatal and Postpartum Care—Timeliness of Prenatal Care	PPC-1
Prenatal and Postpartum Care—Postpartum Care	PPC-2
Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—Who Were Provided Most Effective of Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery—	CCP-1
Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—Who Were Provided Most Effective of Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	CCP-2
Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	CCP-3
Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	CCP-4
Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—Who Were Provided Most Effective of Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	CCP-5
Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—Who Were Provided Most Effective of Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	CCP-6
Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	CCP-7
Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	CCP-8

Table D-4 shows the results for the MMA Standard plans and MMA Specialty plans for all measures within the Women's Care domain. Please note that Freedom-S was excluded from this table because it did not have any reportable rates within the Women's Care domain.

Table D-4—**Women's Care Domain Performance Measure Results**

Measure	AMG-M	BET-M	CCP-M	CHA-S	CMS-S	COV-M	HUM-M	MCC-S	MOL-M	PHC-S	PRS-M	SHP-M	STW-M	SUN-M	SUN-S	URA-M
CCS	61.07%	61.07%	58.15%	70.07%	—	63.66%	59.61%	45.74%	63.99%	68.13%	58.15%	62.53%	59.38%	58.39%	—	63.02%
CHL	67.49%	64.11%	67.13%	79.75%	45.19%	69.58%	65.43%	67.89%	63.90%	NA	61.56%	68.87%	63.33%	64.23%	70.08%	64.12%
BCS[1]	62.57%	57.49%	61.88%	54.77%	—	67.28%	58.53%	40.94%	65.18%	54.17%	57.07%	68.94%	53.80%	58.50%	—	62.25%
PPC-1	83.21%	84.18%	85.40%	73.74%	50.00%	92.37%	79.32%	63.26%	84.05%	NA	83.45%	86.13%	82.78%	79.56%	60.91%	81.75%
PPC-2	65.21%	69.83%	71.78%	69.70%	45.65%	69.47%	66.91%	40.88%	67.09%	NA	62.04%	70.32%	66.94%	60.10%	48.18%	65.45%
CCP-1[2]	0.56%	0.00%	0.00%	NA	0.00%	0.00%	0.00%	2.07%	1.50%	NA	1.46%	0.00%	1.16%	0.85%	2.08%	1.49%
CCP-2[2]	36.59%	29.69%	16.13%	NA	35.71%	25.00%	34.05%	29.31%	37.80%	NA	40.47%	26.42%	37.45%	33.88%	26.04%	35.82%
CCP-3[2]	0.00%	0.00%	0.00%	NA	0.00%	0.00%	0.00%	0.00%	0.23%	NA	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
CCP-4[2]	8.10%	2.08%	0.00%	NA	7.14%	4.76%	5.59%	4.48%	9.13%	NA	7.29%	7.55%	8.21%	7.61%	5.21%	8.96%
CCP-5[2]	13.55%	9.46%	10.82%	19.79%	—	11.05%	8.55%	13.15%	10.53%	NA	11.14%	10.41%	12.65%	9.76%	—	4.47%
CCP-6[2]	41.38%	31.08%	31.97%	36.46%	—	34.08%	37.70%	34.26%	41.22%	NA	42.98%	32.51%	43.14%	37.37%	—	29.20%
CCP-7[2]	0.08%	0.00%	0.00%	0.00%	—	0.00%	0.03%	0.26%	0.03%	NA	0.06%	0.10%	0.04%	0.05%	—	0.00%
CCP-8[2]	6.85%	2.81%	1.62%	1.04%	—	6.49%	4.91%	4.33%	6.69%	NA	7.53%	2.68%	7.95%	7.02%	—	8.17%

[1] *Due to changes in the technical specifications for this measure, a comparison to benchmarks was not performed; therefore, the rates in the table above are presented for information only.*

[2] *AHCA did not set a performance target for this measure for RY 2018.*

NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.

— indicates that the MMA was not required to report a rate for the measure.

Although Freedom-S reported the required Women's Care measures, the MMA was excluded from the table due to reporting rates of "NA" for all Women's Care measures based on small denominators.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

Living With Illness Domain

Table D-5 shows the performance measure names and associated measure name abbreviations for all measures included in the Living With Illness domain.

Table D-5—**Living With Illness Domain Performance Measure Abbreviations**

Performance Measure	Abbreviation
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	CDC-T
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	CDC-9
Comprehensive Diabetes Care—HbA1c Control (<8%)	CDC-8
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	CDC-E
Comprehensive Diabetes Care—Medical Attention for Nephropathy	CDC-N
Controlling High Blood Pressure	CBP
Adult BMI Assessment	ABA
Medication Management for People With Asthma—Medication Compliance 50%—Total	MMA-50
Medication Management for People With Asthma—Medication Compliance 75%—Total	MMA-75
Annual Monitoring for Patients on Persistent Medications—Total	MPM
Plan All-Cause Readmissions—18–64 Years—Total	PCR-1
Plan All-Cause Readmissions—65+ Years—Total	PCR-2
HIV Viral Load Suppression—18–64 Years	VLS-1
HIV Viral Load Suppression—65+ Years	VLS-2
Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total	MSC-A
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total	MSC-M
Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total	MSC-S
Care for Older Adults—Advanced Care Planning—66+ Years	COA-A
Care for Older Adults—Functional Status Assessment—66+ Years	COA-F
Care for Older Adults—Medication Review—66+ Years	COA-M
Care for Older Adults—Pain Assessment—66+ Years	COA-P

Table D-6 shows the results for the MMA Standard plans and MMA Specialty plans for all measures within the Living With Illness domain.

Table D-6—Living With Illness Domain Performance Measure Results

Measure	AMG-M	BET-M	CCP-M	CHA-S	CMS-S	COV-M	FRE-S	HUM-M	MCC-S	MOL-M	PHC-S	PRS-M	SHP-M	STW-M	SUN-M	SUN-S	URA-M
CDC-T	87.35%	84.43%	88.08%	86.13%	79.77%	87.83%	NA	85.89%	79.08%	87.10%	94.20%	84.04%	92.46%	84.52%	85.40%	—	87.10%
CDC-9*	37.23%	39.90%	36.01%	47.93%	100.00%	39.90%	NA	33.82%	51.09%	40.39%	31.16%	50.46%	29.93%	40.54%	45.01%	—	41.61%
CDC-8	49.39%	48.66%	53.77%	46.96%	0.00%	51.82%	NA	52.07%	40.63%	48.91%	65.22%	42.25%	57.42%	51.60%	47.45%	—	49.64%
CDC-E	55.96%	49.64%	66.42%	39.66%	44.36%	55.96%	NA	62.04%	45.50%	58.15%	47.83%	42.10%	52.07%	57.25%	60.83%	—	50.85%
CDC-N	92.46%	93.43%	93.43%	94.89%	74.71%	93.67%	NA	92.99%	91.73%	93.19%	94.93%	91.95%	97.57%	92.14%	93.43%	—	93.19%
CBP	69.59%	55.23%	63.50%	47.93%	—	66.15%	62.50%	67.64%	54.99%	50.36%	65.12%	25.55%	60.58%	58.72%	37.71%	—	55.72%
ABA	95.86%	87.83%	90.41%	91.00%	25.72%	93.71%	NA	94.65%	83.45%	88.21%	98.54%	86.86%	88.81%	89.29%	87.35%	NA	88.81%
MMA-50[1]	55.69%	53.70%	50.87%	77.57%	58.33%	51.20%	—	52.83%	74.29%	54.58%	NA	51.20%	62.93%	56.98%	51.33%	62.50%	54.66%
MMA-75	26.11%	25.62%	22.54%	51.40%	32.23%	30.72%	—	28.42%	57.68%	29.05%	NA	28.04%	32.24%	29.71%	24.98%	33.68%	30.12%
MPM[2]	92.88%	92.64%	93.70%	99.01%	84.87%	94.23%	97.01%	94.71%	92.21%	92.14%	96.86%	89.74%	94.92%	91.99%	92.16%	—	92.90%
PCR-1*[1]	22.04%	21.72%	22.45%	30.05%	—	17.43%	NA	22.27%	31.56%	21.31%	24.03%	17.96%	22.06%	22.18%	23.29%	—	20.52%
PCR-2*[1]	17.31%	12.03%	6.78%	NA	—	13.27%	NA	13.44%	13.72%	13.84%	NA	7.77%	14.03%	16.86%	17.65%	—	4.65%
VLS-1[1]	17.43%	0.00%	12.50%	0.00%	0.00%	19.63%	NA	9.06%	0.00%	0.00%	84.15%	0.00%	0.00%	0.20%	7.30%	NA	51.13%
VLS-2[1]	NA	NA	NA	0.00%	—	NA	NA	10.10%	NA	NA	NA	NA	0.00%	0.00%	NA	—	22.47%
MSC-A	76.81%	NA	NA	89.30%	—	NA	NA	NA	81.71%	NA	NA	78.03%	87.16%	NA	78.38%	—	NA
MSC-M	51.45%	NA	NA	69.39%	—	NA	NA	NA	56.71%	NA	NA	51.15%	60.19%	NA	61.82%	—	NA
MSC-S	47.10%	NA	NA	65.03%	—	NA	NA	NA	48.80%	NA	NA	45.09%	58.33%	NA	49.54%	—	NA
COA-A[1]	—	—	—	—	—	—	75.41%	—	—	—	—	—	—	—	—	—	—
COA-F[1]	—	—	—	—	—	—	86.89%	—	—	—	—	—	—	—	—	—	—
COA-M[1]	—	—	—	—	—	—	88.52%	—	—	—	—	—	—	—	—	—	—
COA-P[1]	—	—	—	—	—	—	90.16%	—	—	—	—	—	—	—	—	—	—

** Indicates that lower rates are better for this measure.*

[1] AHCA did not set a performance target for this measure for RY 2018.

[2] Due to changes in the technical specifications for this measure, a comparison to benchmarks was not performed; therefore, the rates in the table above are presented for information only.

NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.

— indicates that the MMA was not required to report a rate for the measure.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

Behavioral Health Domain

Table D-7 shows the performance measure names and associated measure name abbreviations for all measures included in the Behavioral Health domain.

Table D-7—**Behavioral Health Domain Performance Measure Abbreviations**

Performance Measure	Abbreviation
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	IET-I
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	IET-E
Follow-Up-After Hospitalization for Mental Illness—7-Day Follow-Up	FHM-7
Follow-Up-After Hospitalization for Mental Illness—30-Day Follow-Up	FHM-30
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up	FUM-7
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	FUM-30
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	FUA-7
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	FUA-30
Antidepressant Medication Management—Effective Acute Phase Treatment	AMM-A
Antidepressant Medication Management—Effective Continuation Phase Treatment	AMM-C
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	SAA
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	APM
Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total	APC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	APP
Mental Health Readmission Rate	RER
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD

Table D-8 shows the results for the MMA Standard plans and MMA Specialty plans for all measures within the Behavioral Health domain. Please note that Freedom-S was excluded from this table because it did not have any reportable rates within the Behavioral Health domain.

Table D-8—**Behavioral Health Domain Performance Measure Results**

Measure	AMG-M	BET-M	CCP-M	CHA-S	CMS-S	COV-M	HUM-M	MCC-S	MOL-M	PHC-S	PRS-M	SHP-M	STW-M	SUN-M	SUN-S	URA-M
IET-I[1]	39.45%	31.30%	34.54%	45.47%	48.30%	34.40%	43.03%	51.18%	38.74%	31.91%	35.57%	18.22%	43.45%	46.78%	47.21%	41.45%
IET-E[1]	6.15%	3.35%	5.85%	2.50%	9.09%	6.19%	6.08%	6.17%	6.55%	4.26%	7.94%	2.15%	8.68%	7.87%	12.08%	5.75%
FHM-7[1]	37.92%	24.33%	35.56%	12.44%	38.73%	38.98%	32.94%	23.62%	28.54%	NA	18.72%	24.63%	31.04%	32.66%	44.80%	29.50%
FHM-30[1]	59.11%	44.16%	56.44%	24.53%	63.47%	57.80%	52.21%	42.27%	50.33%	NA	40.00%	40.32%	52.73%	52.78%	71.53%	50.62%
FUM-7[2]	29.82%	22.17%	20.65%	11.70%	46.15%	27.96%	26.58%	33.69%	21.44%	NA	24.18%	27.41%	30.56%	24.33%	52.44%	22.39%
FUM-30[2]	44.96%	36.95%	33.70%	28.72%	65.38%	46.24%	42.67%	49.36%	37.76%	NA	45.85%	44.67%	47.68%	40.19%	77.44%	38.62%
FUA-7[2]	5.03%	4.46%	10.71%	5.19%	0.00%	12.50%	6.09%	8.35%	3.73%	NA	6.87%	18.92%	3.65%	4.54%	0.00%	3.37%
FUA-30[2]	8.12%	5.45%	10.71%	7.41%	3.03%	13.75%	9.08%	11.86%	6.13%	NA	10.07%	19.82%	6.04%	7.01%	4.96%	5.28%
AMM-A	50.05%	48.31%	55.00%	51.76%	65.52%	53.85%	54.97%	57.07%	50.49%	43.86%	53.56%	61.17%	50.19%	50.59%	—	51.35%
AMM-C	33.51%	34.53%	42.50%	41.55%	39.66%	34.34%	39.16%	43.91%	36.02%	38.60%	36.84%	47.56%	34.23%	35.84%	—	35.37%
SAA	60.16%	56.84%	55.29%	45.38%	—	50.29%	65.21%	66.87%	57.54%	42.00%	57.98%	62.19%	58.32%	65.16%	—	65.93%
APM	36.05%	44.00%	50.85%	NA	42.06%	53.85%	38.10%	36.72%	39.06%	NA	36.97%	61.87%	35.12%	37.86%	48.23%	37.27%
APC*	1.51%	3.77%	4.76%	NA	3.05%	3.23%	1.76%	1.45%	0.56%	NA	0.65%	0.00%	1.88%	1.02%	1.19%	1.12%
APP	67.83%	60.61%	56.76%	NA	55.56%	62.50%	59.77%	60.36%	62.63%	NA	57.21%	48.65%	62.70%	60.65%	74.74%	60.08%
RER*[2]	39.50%	20.78%	20.06%	45.60%	62.15%	21.47%	26.37%	46.13%	50.28%	34.31%	23.60%	34.53%	21.49%	38.85%	73.88%	25.38%
SSD	81.68%	83.58%	82.08%	97.99%	68.24%	82.63%	83.28%	74.67%	82.89%	98.44%	80.34%	86.67%	82.68%	83.27%	81.63%	80.40%

** Indicates that lower rates are better for this measure.*

[1] Due to changes in the technical specifications for this measure, a comparison to benchmarks was not performed; therefore, the rates in the table above are presented for information only.

[2] AHCA did not set a performance target for this measure for RY 2018.

NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.

— indicates that the MMA was not required to report a rate for the measure.

Although Freedom-S reported the required Behavioral Health measures, the MMA was excluded from the table due to reporting rates of "NA" for all Behavioral Health measures based on small denominators.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

Access/Availability of Care Domain

Table D-9 shows the performance measure names and associated measure name abbreviations for all measures included in the Access/Availability of Care domain.

Table D-9—Access/Availability of Care Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months	CAP-1
Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years	CAP-2
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years	CAP-3
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years	CAP-4
Adults' Access to Preventive/Ambulatory Health Services—Total	AAP
Call Answer Timeliness	CAT

Table D-10 shows the results for the MMA Standard plans and MMA Specialty plans for all measures within the Access/Availability of Care domain.

Table D-10—Access/Availability of Care Domain Performance Measure Results

Measure	AMG-M	BET-M	CCP-M	CHA-S	CMS-S	COV-M	FRE-S	HUM-M	MCC-S	MOL-M	PHC-S	PRS-M	SHP-M	STW-M	SUN-M	SUN-S	URA-M
CAP-1	95.60%	93.72%	94.23%	NA	97.77%	97.22%	—	93.80%	NA	94.44%	NA	93.49%	95.67%	95.71%	93.11%	97.70%	95.21%
CAP-2	90.78%	85.07%	88.03%	62.30%	94.60%	93.11%	—	87.18%	82.86%	86.63%	NA	85.94%	91.00%	88.80%	85.16%	91.26%	88.32%
CAP-3	91.02%	87.19%	89.95%	NA	96.66%	92.32%	—	87.54%	75.31%	86.30%	NA	86.08%	91.37%	89.49%	84.88%	85.60%	88.05%
CAP-4	88.06%	81.26%	83.36%	NA	95.31%	87.97%	—	84.08%	67.73%	82.65%	NA	81.63%	85.58%	86.55%	80.07%	81.35%	84.85%
AAP	73.96%	67.27%	63.87%	91.09%	—	75.84%	90.79%	78.23%	77.76%	75.20%	92.43%	73.71%	83.53%	77.13%	68.87%	—	77.93%
CAT	88.24%	95.03%	90.32%	96.41%	77.71%	87.82%	95.03%	99.00%	79.41%	97.68%	85.48%	82.66%	94.57%	90.10%	82.50%	79.71%	93.69%

NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.

— indicates that the MMA was not required to report a rate for the measure.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

Use of Services Domain

Table D-11 shows the performance measure names and associated measure name abbreviations for all measures included in the Use of Services domain.

Table D-11—Use of Services Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Ambulatory Care (per 1,000 Member Months)—Outpatient Visits—Total	AMB-O
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total	AMB-E
Use of Opioids at High Dosage	UOD
Use of Opioids from Multiple Providers—Multiple Prescribers	UOP-1
Use of Opioids from Multiple Providers—Multiple Pharmacies	UOP-2
Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies	UOP-3

Table D-12 shows the results for the MMA Standard plans and MMA Specialty plans for all measures within the Use of Services domain.

Table D-12—Use of Services Domain Performance Measure Results

Measure	AMG-M	BET-M	CCP-M	CHA-S	CMS-S	COV-M	FRE-S	HUM-M	MCC-S	MOL-M	PHC-S	PRS-M	SHP-M	STW-M	SUN-M	SUN-S	URA-M
AMB-O[1]	300.42	267.56	282.31	411.87	485.84	356.73	310.61	346.95	234.71	320.10	495.00	304.55	379.41	346.46	282.03	297.57	319.44
AMB-E*	63.95	65.20	60.48	149.04	71.19	62.75	53.66	66.60	150.77	69.29	164.97	73.91	53.39	72.11	66.71	53.45	73.85
UOD*[2]	114.92	122.64	115.50	162.91	—	167.27	NA	62.20	92.98	59.30	0.00	114.50	149.29	75.54	103.91	—	64.26
UOP-1*[2]	217.23	774.87	229.21	779.85	—	177.33	NA	202.58	768.38	262.34	139.78	217.18	719.75	220.11	215.44	—	241.46
UOP-2*[2]	54.12	774.87	87.64	779.85	—	114.83	NA	75.33	768.38	79.54	53.76	162.36	719.75	73.94	70.36	—	39.70
UOP-3*[2]	33.35	774.87	65.17	779.85	—	58.14	NA	42.59	768.38	51.01	21.51	79.81	719.75	44.60	42.59	—	27.70

** Indicates that lower rates are better for this measure.*

[1] AHCA did not set a performance target for this measure for RY 2018.

[2] This measure was new for RY 2018; therefore, comparisons to performance targets could not be made.

— indicates that the MMA was not required to report a rate for the measure.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below the minimum performance target.

LTC Plan-Specific Results

Table D-13 shows the performance measure names and associated measure name abbreviations for all LTC Plan-specific measures.

Table D-13—LTC Plan-Specific Performance Measure Abbreviations

Performance Measure	Abbreviation
Care for Adults—Advance Care Planning—Total	CFA-ACP
Care for Adults—Medication Review—Total	CFA-Review
Care for Adults—Functional Status Assessment—Total	CFA-FSA
Call Answer Timeliness	CAT
Required Record Documentation—701B Assessment	RRD-701B
Required Record Documentation—Plan of Care—Enrollee Participation	RRD-Enrollee
Required Record Documentation—Plan of Care—PCP Notification	RRD-PCP
Required Record Documentation—Freedom of Choice Form	RRD-FCF
Required Record Documentation—Plan of Care—LTC Service Authorizations	RRD-Auth
Face-to-Face Encounters	F2F
Case Manager Training	CMT
Timeliness of Services	TOS

Table D-14 shows the results for the LTC plans for all measures reported for RY 2018.

Table D-14—LTC Plan-Specific Performance Measure Results

Measure	AMG-L	COV-L	HUM-L	MOL-L	SUN-L	URA-L
CFA-ACP[1]	96.11%	83.78%	92.71%	98.78%	96.88%	88.56%
CFA-Review[1]	95.89%	97.78%	99.53%	59.00%	94.06%	25.30%
CFA-FSA[1]	97.32%	91.56%	89.40%	98.54%	96.43%	92.46%
CAT[2]	48.33%	94.06%	98.52%	97.68%	73.62%	94.15%
RRD-701B[1]	90.27%	92.89%	92.86%	96.35%	97.32%	81.51%
RRD-Enrollee[1]	82.48%	99.33%	89.05%	92.21%	69.59%	48.66%
RRD-PCP[1]	90.75%	80.89%	83.81%	97.08%	54.01%	55.72%
RRD-FCF[1]	91.73%	95.78%	98.81%	90.27%	79.08%	42.34%
RRD-Auth*[1]	0.00%	0.00%	1.19%	0.24%	1.22%	0.97%
F2F[1]	75.94%	86.56%	91.09%	87.82%	94.86%	55.67%
CMT[1]	93.75%	94.17%	93.79%	100.00%	98.18%	98.34%
TOS[1]	93.30%	95.32%	90.79%	88.81%	94.54%	44.86%

** Indicates that lower rates are better for this measure.*

[1] AHCA did not set a performance target for this measure for RY 2018.

[2] This measure is compared to the Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015, which is the most recent year available for this measure.

Indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

Indicates that the performance measure rate for RY 2018 ranked below minimum performance target.

Attachment VI
Performance Measure Validation Report

Florida Agency for Health Care Administration

Performance Measure Validation Findings Report

February 2019

Table of Contents

Acronyms

AAP ..... *Adults' Access to Preventive/Ambulatory Health Services*
ABA ..... *Adult BMI Assessment*
ACE ..... Angiotensin Converting Enzyme

ADD.....*Follow-Up Care for Children Prescribed ADHD Medication*
ADHD.....Attention-deficit/Hyperactivity Disorder
ADL.....Activities of Daily Living
ADV.....*Annual Dental Visit*
AHCA.....Florida Agency for Health Care Administration
AIDS.....Acquired Immunodeficiency Syndrome
AMB.....*Ambulatory Care*
AMM.....*Antidepressant Medication Management*
AOD.....Alcohol and Other Drug
APC.....*Use of Multiple Concurrent Antipsychotics in Children and Adolescents*
APM.....*Metabolic Monitoring for Children and Adolescents on Antipsychotics*
APP.....*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics*
ARB.....Angiotensin Receptor Blockers
AWC.....*Adolescent Well-Care Visits*
BAT.....Baseline Assessment Tool
BBA.....Balanced Budget Act of 1997
BCS.....*Breast Cancer Screening*
BMI.....Body Mass Index
BR.....*Biased Rate*
C&M.....Continuation and Maintenance
CAHPS.....Consumer Assessment of Healthcare Providers and Systems
CAP.....*Children and Adolescents' Access to Primary Care Practitioners*
CAT.....*Call Answer Timeliness*
CBP.....*Controlling High Blood Pressure*
CCS.....*Cervical Cancer Screening*
CDC.....*Comprehensive Diabetes Care*
CFA.....*Care for Adults*
CFR.....Code of Federal Regulations
CHL.....*Chlamydia Screening in Women*
CIS.....*Childhood Immunization Status*
CLIA.....Clinical Laboratory Improvement Amendments
CMS.....Centers for Medicare & Medicaid Services
CMT.....*Case Manager Training*
COA.....*Care for Older Adults*
CPT.....Current Procedural Terminology
CY.....Calendar Year
CCP.....*Contraceptive Care—Postpartum Women*
DRG.....Diagnosis-related Group
DTaP.....Diphtheria, Tetanus, and Acellular Pertussis
ED.....Emergency Department
EDD.....Estimated Date of Delivery
EQRO.....External Quality Review Organization

F2F ..... *Face-to-Face Encounters*
FDA ..... Food and Drug Administration
FAR ..... Final Audit Report
FFS ..... Fee-for-Service
FHM ..... *Follow-Up After Hospitalization for Mental Illness*
FUA ..... *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*
FUM ..... *Follow-Up After Emergency Department Visit for Mental Illness*
FSS ..... Final Sample Size
HbA1c ..... Hemoglobin A1c
HCPCS ..... Healthcare Common Procedure Coding System
HEDIS ..... Healthcare Effectiveness Data and Information Set
HepB ..... Hepatitis B
HiB ..... Haemophilus Influenza Type B
HIV ..... Human Immunodeficiency Virus
HMO ..... Health Maintenance Organization
HPV ..... Human Papillomavirus
HSAG ..... Health Services Advisory Group, Inc.
IDSS ..... Interactive Data Submission System
IESD ..... Index Episode Start Date
IET ..... *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*
IMA ..... *Immunizations for Adolescents*
IPSD ..... Index Prescription Start Date
IPV ..... Inactivated Polio Vaccine
IS ..... Information System
IT ..... Information Technology
LARC ..... Long-Acting Reversible Method of Contraception
LDL-C ..... Low-density Lipoprotein Cholesterol
LO ..... Licensed Organization
LOINC ..... Logical Observation Identifiers Names and Codes
LSC ..... *Lead Screening in Children*
LTC ..... Long-term Care
MAT ..... Medication Assisted Treatment
MCO ..... Managed Care Organization
MM ..... Member Months
MMA ..... Managed Medical Assistance
MMA ..... *Medication Management for People With Asthma*
MMR ..... Measles, Mumps, and Rubella
MPM ..... *Annual Monitoring for Patients on Persistent Medications*
MRR ..... Medical Record Review
MRRV ..... Medical Record Review Validation
MSC ..... *Medical Assistance With Smoking and Tobacco Use Cessation*
NA ..... *Small Denominator*

NB ..... *No Benefit*
NCQA ..... National Committee for Quality Assurance
NDC ..... National Drug Code
NR ..... *Not Reported*
NQ ..... *Not Required*
OB/GYN ..... Obstetrician/Gynecologist
PCP ..... Primary Care Practitioner
PCR ..... *Plan All-Cause Readmissions*
PCV ..... Pneumococcal Conjugate Vaccine
PMV ..... Performance Measure Validation
PPC ..... *Prenatal and Postpartum Care*
PSN ..... Provider Service Network
R ..... *Reportable*
RER ..... *Mental Health Readmission Rate*
Roadmap ..... Record of Administration, Date Management, and Processes
RRD ..... *Required Record Documentation*
RY ..... Reporting Year
SAA ..... *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
SEAL ..... *Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk*
SFY ..... State Fiscal Year
SMI ..... Serious Mental Illness
SMMC ..... Statewide Medicaid Managed Care
SSD ..... *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications*
TOS ..... *Timeliness of Service*
UN ..... *Un-Audited*
UOD ..... *Use of Opioids at High Dosage*
UOP ..... *Use of Opioids From Multiple Providers*
VLS ..... *HIV Viral Load Suppression*
VZV ..... Varicella Zoster Virus (Chicken Pox)
W15 ..... *Well-Child Visits in the First 15 Months of Life*
W34 ..... *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
WCC ..... *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

8. Executive Summary

Introduction

The Florida Agency for Health Care Administration (AHCA) is responsible for providing oversight and administration of the Medicaid program in Florida, including the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. Under the MMA program, there are Standard MMA plans and Specialty MMA plans. The Specialty MMA plans serve Medicaid enrollees who are in the child welfare system, who are under the age of 21 with chronic conditions, who have human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), who are diagnosed with a serious mental illness (SMI), or who are Medicare-Medicaid dual-eligible adult enrollees with chronic diseases. The LTC program is a system for Medicaid enrollees to receive long-term care services.

As part of AHCA's annual reporting requirements, all plans must use Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications for calculating indicators of the quality of, access to, and timeliness of care.[1-1] AHCA also requires that plans report other quality indicator data. Each plan must submit to AHCA its indicator data with certification from an independent National Committee for Quality Assurance- (NCQA-) certified auditor approved by AHCA. According to their contracts with AHCA, these plans reported calendar year (CY) 2017 measure results by July 1, 2018 (reporting year [RY] 2018). For the CY 2017 measurement period, 11 Standard MMA plans, six Specialty MMA plans, and six LTC plans reported performance measure results to AHCA.

AHCA selected the performance measures to evaluate the MMA plans within the following six domains: Pediatric Care, Women's Care, Living With Illness, Behavioral Health, Access/Availability of Care, and Use of Services. Of note, results presented in the Use of Services measure domain assess plan members' use of services and do not take into consideration the demographic and clinical characteristics of each plan's enrollees; therefore, these rates in isolation do not necessarily correlate with the quality of services provided and are provided for information only.

AHCA contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to conduct performance measure validation (PMV) activities for measures calculated and reported by the MMA and LTC plans for CY 2017. All indicator data were audited by the plan's NCQA-certified auditor; therefore, HSAG's role in the validation of performance measures was to ensure that validation activities conducted were consistent with the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External*

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Quality Review (EQR), Version 2.0, September 1, 2012[1-2]; review the independent auditing process already conducted; and verify that performance measure rates were collected, reported, and calculated according to the specifications required by the State. This report compiles all PMV findings and results from the plans. Throughout the report, specific plans are referenced by either their shortened name or abbreviation; see Table 9-1 for a list of full MMA and LTC plan names.

Summary of MMA Plan Results

Table 8-1 displays the Florida statewide averages for HEDIS 2017 and HEDIS 2018. HSAG calculated a statewide weighted average for each measure based on the plans' eligible population sizes. Cells shaded gray indicate the measure indicators with a 2018 performance target established by AHCA, and cells shaded green indicate performance rates that met or exceeded AHCA's 2018 performance targets.

Table 8-1—Florida Medicaid MMA Program Statewide Averages

Measure	RY 2017	RY 2018
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	1.97%	1.97%
Six or More Well-Child Visits	63.50%	69.48%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.66%	77.94%
Childhood Immunization Status		
Combination 2	78.21%	78.16%
Combination 3	74.22%	73.71%
Lead Screening in Children		
Lead Screening in Children	65.85%	67.48%
Follow-Up Care for Children Prescribed Attention-deficit/Hyperactivity Disorder (ADHD) Medication[1]		
Initiation Phase	48.55%	48.22%
Continuation and Maintenance Phase	65.09%	63.90%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	78.40%	82.76%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	52.91%	57.22%
Immunizations for Adolescents		
Combination 1	70.62%	71.93%

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf.

Measure	RY 2017	RY 2018
Combination 2[2]	—	30.45%
Annual Dental Visit		
Total	48.55%	50.87%

Measure	RY 2017	RY 2018
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	30.41%	28.26%
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	56.08%	59.84%
Chlamydia Screening in Women		
Total	62.55%	64.31%
Breast Cancer Screening[2]		
Breast Cancer Screening	—	58.17%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	84.26%	81.93%
Postpartum Care	63.55%	64.54%
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	—	1.00%
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	—	35.57%
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	—	0.03%
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	—	7.40%
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	—	10.83%
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	—	39.41%
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	—	0.05%
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	—	6.65%

Measure	RY 2017	RY 2018
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	81.95%	85.69%
*HbA1c Poor Control (>9.0%)**	45.41%	40.90%
HbA1c Control (<8.0%)	44.09%	49.22%
Eye Exam (Retinal) Performed	55.87%	55.26%
Medical Attention for Nephropathy	90.91%	92.88%
Controlling High Blood Pressure		
Controlling High Blood Pressure	54.85%	55.03%
Adult BMI Assessment		
Adult BMI Assessment	87.21%	89.68%
Medication Management for People With Asthma		
Medication Compliance 50%—Total	54.00%	55.35%
Medication Compliance 75%—Total	28.82%	28.98%
Annual Monitoring for Patients on Persistent Medications[2]		
Total	—	92.92%
Plan All-Cause Readmissions		
*18–64 Years—Total**	24.01%	23.24%
*65+ Years—Total**	13.45%	13.56%
HIV Viral Load Suppression[3]		
18–64 Years	13.62%	10.80%
65+ Years	6.53%	4.10%
Medical Assistance With Smoking and Tobacco Use Cessation[4]		
Advising Smokers and Tobacco Users to Quit—Total	41.23%	82.23%
Discussing Cessation Medications—Total	27.64%	56.73%
Discussing Cessation Strategies—Total	25.59%	51.50%
Care for Older Adults		
Advance Care Planning—66+ Years	85.19%	75.41%
Functional Status Assessment—66+ Years	90.74%	86.89%
Medication Review—66+ Years	94.44%	88.52%
Pain Assessment—66+ Years	96.30%	90.16%
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment[2]		
Initiation of AOD Treatment—Total—Total	—	41.80%
Engagement of AOD Treatment—Total—Total	—	6.90%
Follow-Up After Hospitalization for Mental Illness[2]		
7-Day Follow-Up	—	30.52%

Measure	RY 2017	RY 2018
30-Day Follow-Up	—	51.14%

Measure	RY 2017	RY 2018
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	33.05%	28.05%
30-Day Follow-Up	51.14%	45.22%
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—Total	9.69%	5.52%
30-Day Follow-Up—Total	12.30%	8.21%
Antidepressant Medication Management[1]		
Effective Acute Phase Treatment	51.38%	52.58%
Effective Continuation Phase Treatment	35.72%	37.21%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	63.31%	62.68%
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Total	38.06%	38.90%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*Total**	1.64%	1.71%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[1]		
Total	—	62.63%
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	33.52%	40.92%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.62%	80.75%
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	94.37%	94.62%
25 Months–6 Years	87.82%	87.84%
7–11 Years	88.75%	88.21%
12–19 Years	85.16%	84.46%
Adults' Access to Preventive/Ambulatory Health Services		
Total	74.11%	75.50%
Call Answer Timeliness		
Call Answer Timeliness	87.70%	90.48%
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	320.89	320.24

Measure	RY 2017	RY 2018
*ED Visits—Total**	71.22	70.09

Measure	RY 2017	RY 2018
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	—	87.31
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	—	280.89
*Multiple Pharmacies**	—	154.51
*Multiple Prescribers and Multiple Pharmacies**	—	124.11

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.
[2] Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between RY 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.
[3] Due to issues associated with the plans obtaining complete HIV/AIDS lab data for this measure, low rates may be associated with a lack of complete data rather than cases of non-suppression of HIV viral load. Therefore, caution should be exercised when interpreting results.
[4] To align with calculations from prior years, the weighted average for this measure used the eligible population for the survey rather than the number of people who responded as being smokers.
— indicates that the RY 2017 rate is not presented because the MMA plans were not required to report the measure until RY 2018. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2017 rate is not displayed.
Gray shading indicates that AHCA established a performance target for the measure for RY 2018.
Green shading indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

The statewide average rates for the following measures met or exceeded AHCA's 2018 performance targets for the MMA program:

- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
- *Chlamydia Screening in Women—Total*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total*, *Discussing Cessation Medications—Total*, and *Discussing Cessation Strategies—Total*
- *Call Answer Timeliness*

Pediatric Care

For the Pediatric Care domain, seven of 13 statewide average rates (approximately 54 percent) that could be compared to the prior year's rates demonstrated statistically significant increases from RY 2017 to RY 2018. Additionally, three of 12 statewide average rates (approximately 25 percent) were at or above the national Medicaid 75th percentile. Of note, the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for*

Children/Adolescents—BMI Percentile Documentation—Total measures were areas of strength in this domain, as the statewide averages for these measures were both above the national Medicaid 75th percentile and demonstrated statistically significant increases.

Conversely, four of 12 statewide average rates (approximately 33 percent) fell below the national Medicaid 50th percentile; however, three of these statewide average rates demonstrated statistically significant increases from RY 2017 to RY 2018. Of note, although the statewide average for *Annual Dental Visit—Total* fell below the 50th percentile, 14 MMA plans demonstrated statistically significant increases in RY 2018 for this measure. Additionally, the statewide average rate for *Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk* demonstrated a statistically significant decline from RY 2017 to RY 2018, further demonstrating opportunities to improve care for children.

Women's Care

For the Women's Care domain, three of four statewide average rates (75 percent) that could be compared to national Medicaid benchmarks or the prior year's rates demonstrated statistically significant increases from RY 2017 to RY 2018. Of note, the *Chlamydia Screening in Women—Total* statewide average rate was above the national Medicaid 75th percentile and demonstrated a statistically significant increase, indicating an area of strength for this domain.

Conversely, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* statewide average rate demonstrated a statistically significant decline from RY 2017 and RY 2018 and fell below the national Medicaid 50th percentile, demonstrating opportunities to improve care for pregnant women.

Living With Illness

For the Living With Illness domain, 10 of 20 statewide average rates (50 percent) that could be compared to national Medicaid percentiles or the prior year's rates demonstrated statistically significant increases from RY 2017 to RY 2018. Additionally, four of 12 statewide average rates (approximately 33 percent) exceeded the national Medicaid 75th percentile. Of note, the three *Medical Assistance With Smoking and Tobacco Use Cessation* statewide average rates exceeded the national Medicaid 75th percentile and had statistically significant increases greater than 25 percentage points, demonstrating strengths for this domain.

Conversely, four of 12 statewide average rates (approximately 33 percent) fell below the national Medicaid 50th percentile; however, two of these rates demonstrated statistically significant improvements from RY 2017 to RY 2018. Additionally, the statewide average rate for *HIV Viral Load Suppression—18–64 Years* demonstrated a statistically significant decline from RY 2017 to RY 2018, further demonstrating opportunities to improve care for enrollees with chronic conditions.

Behavioral Health

For the Behavioral Health domain, one of 11 statewide average rates (approximately 9 percent) that could be compared to the prior year's rates demonstrated a statistically significant increase from RY 2017 to RY 2018.

Conversely, five of 11 statewide average rates (approximately 45 percent) that could be compared to national Medicaid percentiles fell below the national Medicaid 50th percentile. Additionally, the statewide average and 12 MMA plans demonstrated statistically significant declines in performance for the *Mental Health Readmission Rate* in RY 2018. Of note, the *Follow-Up After ED Visit for Mental Illness* and *Follow-Up After ED Visit for AOD Abuse or Dependence* measures present opportunities for improvement, as the statewide averages for all four indicators were below the national Medicaid 25th percentile and demonstrated statistically significant declines. Additionally, although caution should be exercised when trending these measures due to changes to the technical specifications, NCQA states that trending can still be performed. Further, the addition of telehealth to conduct appropriate follow-up visits should increase the rates. Given that the rates had statistically significant declines over the prior year, the declines are most likely due to an actual decrease in performance; therefore, the comparison to the prior year is valid.

Access/Availability of Care

For the Access/Availability of Care domain, three of six statewide average rates (50 percent) demonstrated statistically significant increases from RY 2017 to RY 2018. Additionally, the statewide average for *Call Answer Timeliness* ranked above the national Medicaid 75th percentile and demonstrated a statistically significant increase from RY 2017 to RY 2018, with 12 MMA plans demonstrating a statistically significant improvement in RY 2018 for this measure.

Conversely, five of six statewide average rates (approximately 83 percent) fell below the national Medicaid 50th percentile, with two statewide average rates (*Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* and *Adults' Access to Preventive/Ambulatory Health Services—Total*) falling below the national Medicaid 25th percentile. Additionally, the statewide average rates for *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* fell below the 50th percentile and demonstrated statistically significant declines from RY 2017 to RY 2018, further demonstrating opportunities to improve access to care for children and adults.

Use of Services

In the Use of Services domain, for the *Outpatient Visits—Total* and *ED Visits—Total* indicators, the statewide average varied by less than two visits per 1,000 member months from RY 2017 to RY 2018. The *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures were new for RY 2018; therefore, the prior year's results were not available for comparison.

Summary of LTC Plan Results

Table 8-2 displays the LTC program weighted averages for RY 2017 and RY 2018. The *Call Answer Timeliness* measure is shaded gray to indicate that this is the only measure with a 2018 performance

target established by AHCA. Cells shaded green indicate performance rates that met or exceeded AHCA's RY 2018 performance targets.

Table 8-2—Florida Medicaid LTC Program Weighted Averages

Measure	RY 2017	RY 2018
LTC		
Care for Older Adults		
Advance Care Planning—Total	83.99%	94.70%
Medication Review—Total	31.85%	79.40%
Functional Status Assessment—Total	92.38%	93.21%
Call Answer Timeliness		
Call Answer Timeliness gray	87.87%	93.86%
Required Record Documentation		
701B Assessment	89.71%	96.12%
Plan of Care—Enrollee Participation	73.71%	74.71%
Plan of Care—PCP Notification	56.51%	64.18%
Freedom of Choice Form	84.39%	82.06%
*Plan of Care—LTC Service Authorizations**	0.63%	1.08%
Face-to-Face Encounters		
Face-to-Face Encounters	76.41%	84.37%
Case Manager Training		
Case Manager Training	97.01%	96.88%
Timeliness of Service		
Timeliness of Service	71.43%	81.05%

** For this indicator, a lower rate indicates better performance.*
Gray shading indicates that AHCA established a performance target for the measure for RY 2018.
Green shading indicates that the performance measure rate for RY 2018 met or exceeded the performance target.

The *Call Answer Timeliness* statewide average rate exceeded AHCA's 2018 performance target for the LTC program.

Limitations and Considerations

The Specialty MMA plans serve enrollees with certain chronic conditions or specific diagnoses, or those in certain age groups. Although the Specialty MMA plans provide the same services as the Standard MMA plans, these plans may have certain types of providers or primary care physicians available in their network to serve the unique population. As these plans serve unique populations, caution should be exercised when comparing rates for the Specialty MMA plans to one another and to the Standard MMA plans.

9. How to Get the Most From This Report

Introduction

This reader's guide is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

Plan Names

Table 9-1 below presents the state fiscal year (SFY) 2018 Standard and Specialty MMA plans and LTC plans discussed within this report and their corresponding shortened names and abbreviations. The letter at the end of the plan abbreviation identifies the type of plan and population served (i.e., M indicates a Standard MMA plan, S indicates a Specialty MMA plan, and L indicates an LTC plan).

Table 9-1—Florida Medicaid SFY 2017–2018 MMA Plans

Plan Name	Shortened Name	Plan Abbreviation
Standard MMA Plans		
Amerigroup Community Care	Amerigroup	AMG-M
Better Health	Better Health	BET-M
Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida, Inc.	Aetna Better Health	COV-M
Humana Medical Plan, Inc.	Humana	HUM-M
Molina Healthcare of Florida, Inc.	Molina	MOL-M
Prestige Health Choice	Prestige	PRS-M
Simply Healthcare Plans, Inc.	Simply	SHP-M
South Florida Community Care Network d/b/a Community Care Plan	Community Care Plan	CCP-M
Sunshine State Health Plan, Inc.	Sunshine	SUN-M
UnitedHealthcare of Florida, Inc.	United	URA-M
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	Staywell	STW-M

Plan Name	Shortened Name	Plan Abbreviation
Specialty MMA Plans		
AHF MCO of Florida, Inc. d/b/a Positive Healthcare, Inc.	Positive-S	PHC-S
Children's Medical Services Network	Children's Medical Services-S	CMS-S
Clear Health Alliance	Clear Health-S	CHA-S
Freedom Health, Inc.	Freedom-S	FRE-S
Magellan Complete Care	Magellan-S	MCC-S
Sunshine State Health Plan, Inc.	Sunshine-S	SUN-S
LTC Plans		
Amerigroup Community Care	Amerigroup-LTC	AMG-L
Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida, Inc.	Aetna Better Health-LTC	COV-L
Humana Medical Plan, Inc.	Humana-LTC	HUM-L
Molina Healthcare of Florida, Inc.	Molina-LTC	MOL-L
Sunshine State Health Plan, Inc.	Sunshine-LTC	SUN-L
UnitedHealthcare of Florida, Inc.	United-LTC	URA-L

Specialty MMA Plans

As previously noted, the Specialty MMA plans provide the same services as the Standard MMA plans but to unique populations. The Specialty MMA plans serve the following eligible enrollees:

- Clear Health-S and Positive-S (HIV/AIDS Specialty Plan) serve Medicaid enrollees diagnosed with or in treatment for HIV or AIDS.
- Children's Medical Services-S (Children's Medical Services Network Plan) serves Medicaid enrollees under the age of 21 who meet the Department of Health's clinical screening criteria for chronic conditions.
- Freedom-S (Chronic Disease Specialty Plan) serves Medicaid enrollees 21 years of age and older who are Medicare-Medicaid dual-eligible and have a diagnosis of diabetes, chronic obstructive pulmonary disease, congestive heart failure, or cardiovascular disease.
- Magellan-S (Serious Mental Illness Specialty Plan) serves Medicaid enrollees six years of age and older who are diagnosed with or in treatment for a serious mental illness (SMI). This Specialty MMA plan assists enrollees who are diagnosed with schizophrenia, schizoaffective disorder,

delusional disorder, bipolar disorder, major depression, or obsessive-compulsive disorder; and those who are treated with a medication used to treat one of these disorders.

- Sunshine-S (Child Welfare Specialty Plan) serves Medicaid enrollees under the age of 21 who have an open case for child welfare services in the Department of Children and Families' Florida Safe Families Network database.

Summary of Performance Measures

Within this report, HSAG presents the statewide average and MMA and LTC plan-specific performance on measures selected by AHCA for RY 2018.

MMA Plans

The measures for the MMA plans were grouped into the following six domains of care: Pediatric Care, Women's Care, Living With Illness, Behavioral Health, Access/Availability of Care, and Use of Services. While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages MMA plans and AHCA to consider the measures as a whole rather than in isolation and to develop the strategic and tactical changes required to improve overall performance. Table 9-2 shows the selected RY 2018 measures and measure indicators as well as the corresponding domains of care and the measure source for each measure.

Table 9-2—RY 2018 MMA Plan Performance Measures

Measure by Domain	Measure Source
Pediatric Care	
Well-Child Visits in the First 15 Months of Life (W15)—No Well-Child Visits and *Six or More Well-Child Visits*	HEDIS
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	HEDIS
Childhood Immunization Status (CIS)—Combinations 2 and *3*	HEDIS
Lead Screening in Children (LSC)	HEDIS
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	HEDIS
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile Documentation—Total	HEDIS
Adolescent Well-Care Visits (AWC)	HEDIS
Immunizations for Adolescents (IMA)—Combinations 1 and *2*	HEDIS
Annual Dental Visit (ADV)—Total	HEDIS
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk (SEAL)	Medicaid Child Core Set

Measure by Domain	Measure Source
Women's Care	
Cervical Cancer Screening (CCS)	HEDIS
Chlamydia Screening in Women (CHL)—Total	HEDIS
Breast Cancer Screening (BCS)	HEDIS
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and *Postpartum Care*	HEDIS
Contraceptive Care—Postpartum Women—Ages 15–20 Years (CCP-CH), Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery and *Within 60 Days of Delivery*; and *Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery* and *Within 60 Days of Delivery*	Medicaid Child Core Set
Contraceptive Care—Postpartum Women—Ages 21–44 Years (CCP-AD), Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery and *Within 60 Days of Delivery*; and *Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery* and *Within 60 Days of Delivery*	Medicaid Adult Core Set
Living With Illness	
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8%), Eye Exam (Retinal) Performed, and *Medical Attention for Nephropathy*	HEDIS
Controlling High Blood Pressure (CBP)	HEDIS
Adult BMI Assessment (ABA)	HEDIS
Medication Management for People With Asthma (MMA)—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	HEDIS
Annual Monitoring for Patients on Persistent Medications (MPM)—Total	HEDIS
Plan All-Cause Readmissions (PCR)—18–64 Years—Total and *65+ Years—Total*	Medicaid Adult Core Set
HIV Viral Load Suppression (VLS)—18–64 Years and *65+ Years*	Medicaid Adult Core Set
Medical Assistance With Smoking and Tobacco Use Cessation (MSC)—Advising Smokers and Tobacco Users to Quit—Total, Discussing Cessation Medications—Total, and *Discussing Cessation Strategies—Total*	HEDIS
Care for Older Adults (COA)—Advance Care Planning—66+ Years, Medication Review—66+ Years, Functional Status Assessment—66+ Years, and *Pain Assessment—66+ Years*	HEDIS
Behavioral Health	
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total—Total and *Engagement of AOD Treatment—Total—Total*	HEDIS

Measure by Domain	Measure Source
Follow-Up After Hospitalization for Mental Illness (FHM)—7-Day Follow-Up and *30-Day Follow-Up*	HEDIS & AHCA-Defined
Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM)—7-Day Follow-Up and *30-Day Follow-Up*	HEDIS
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	HEDIS
Antidepressant Medication Management (AMM)—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	HEDIS
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	HEDIS
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total	HEDIS
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)—Total	HEDIS
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)—Total	HEDIS
Mental Health Readmission Rate (RER)	AHCA-Defined
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	HEDIS
Access/Availability of Care	
Children and Adolescents' Access to Primary Care Practitioners (CAP)—12–24 Months, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*	HEDIS
Adults' Access to Preventive/Ambulatory Health Services (AAP)—Total	HEDIS
Call Answer Timeliness (CAT)	AHCA-Defined
Use of Services	
Ambulatory Care (per 1,000 Member Months) (AMB)—Outpatient Visits—Total and *ED Visit—Total*	HEDIS
Use of Opioids at High Dosage (UOD)	HEDIS
Use of Opioids From Multiple Providers (UOP)—Multiple Prescribers, *Multiple Pharmacies*, and *Multiple Prescribers and Multiple Pharmacies*	HEDIS

LTC Plans

Table 9-3 shows the RY 2018 measures selected by AHCA for the LTC plans.

Table 9-3—RY 2018 LTC Plan Performance Measures

Measure	Measure Source
Care for Older Adults (CFA)—Advance Care Planning—Total, Medication Review—Total, and Functional Status Assessment—Total	HEDIS & AHCA-Defined
Call Answer Timeliness (CAT)	AHCA-Defined
Required Record Documentation (RRD)—701B Assessment, Plan of Care—Enrollee Participation, Plan of Care—Primary Care Physician (PCP) Notification, Freedom of Choice Form, and *Plan of Care—LTC Service Authorizations*	AHCA-Defined
Face-to-Face Encounters (F2F)	AHCA-Defined
Case Manager Training (CMT)	AHCA-Defined
Timeliness of Service (TOS)	AHCA-Defined

Data Collection Methods

Administrative Method

The administrative method requires that MMA and LTC plans identify the eligible population (i.e., the denominator) using administrative data derived from claims and encounters. In addition, the numerator(s), or services provided to the enrollees in the eligible population, are derived solely using administrative data collected during the reporting year. Medical record review data from the prior year may be used as supplemental data. Medical records collected during the current year cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

Hybrid Method

The hybrid method requires that MMA and LTC plans identify the eligible population using administrative data and then extract a systematic sample of enrollees from the eligible population, which becomes the denominator. Administrative data are used to identify services provided to those enrollees. Medical records must then be reviewed for those enrollees who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher rates because the completeness of documentation in the medical record exceeds what is typically captured in administrative data; however, the medical record review component of the hybrid method is considered more labor intensive. For example, an MMA plan chooses to use the hybrid method for the *Prenatal and Postpartum Care* measure in hopes to capture more numerator hits and produce a higher rate. The MMA plan identified 10,000 enrollees in the eligible population based on administrative data. After systematically selecting 411 eligible enrollees, the MMA plan finds that 161 enrollees had evidence of a postpartum visit using administrative data. The MMA

plan then obtains and reviews medical records for the 250 enrollees who did not have evidence of a postpartum visit using administrative data.

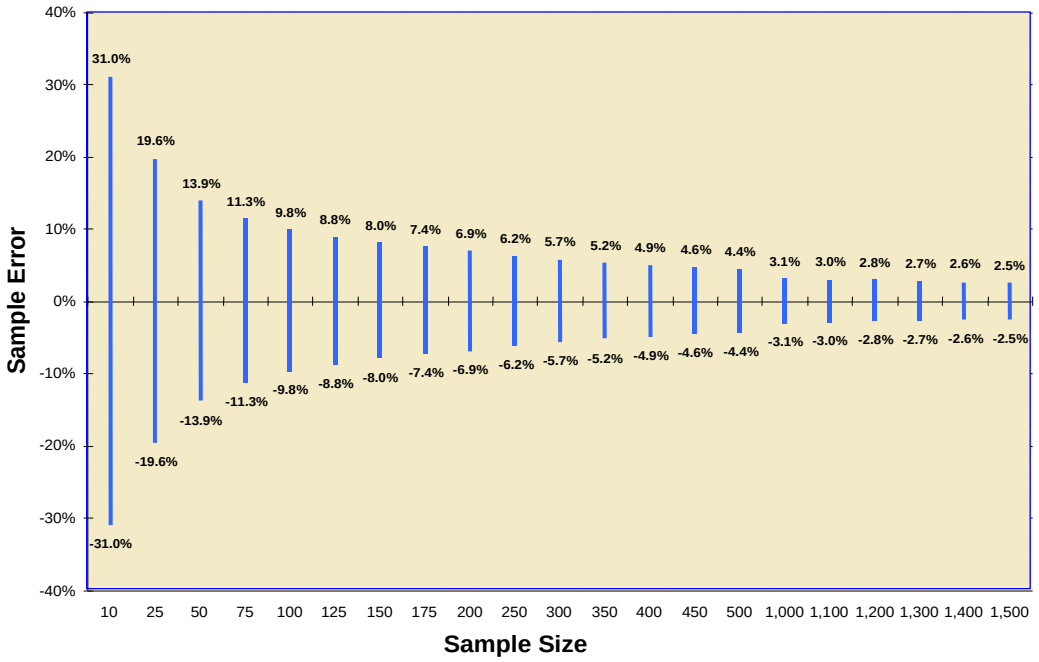
Understanding Sampling Error

Correct interpretation of results for measures collected using the hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to complete medical record review for the entire eligible population for a given measure. Measures collected using the hybrid method include only a sample from the eligible population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire eligible population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The hybrid method prescribes a systematic sampling process selecting at least 411 enrollees of the eligible population. The plan may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*). If there are fewer than 411 enrollees in the eligible population, then the entire eligible population is included in the hybrid sample.

Figure 9-1 shows that if 411 enrollees are included in a measure, the margin of error is approximately ± 4.9 percentage points. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000. The smaller the sample included in the measure, the larger the sampling error.

Figure 9-1—Relationship of Sample Size to Sample Error



As Figure 9-1 shows, sample error decreases as the sample size grows. Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant. This

does not mean that all such differences are important. On the other hand, the difference between two measured rates may not be statistically significant but may, nevertheless, be important. The judgment of the reviewer is always a requisite for meaningful data interpretation.

Survey Method

Results for the *Medical Assistance With Smoking and Tobacco Use Cessation* measure were collected from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version[2-1] following the *HEDIS 2018, Volume 3: Specifications for Survey Measures*. The survey is designed to capture consumer and patient perspectives on healthcare quality.

Data Sources and Measure Audit Results

MMA plan-specific performance displayed in this report was based on data elements obtained from the Interactive Data Submission System (IDSS) files supplied by the MMA plans. Prior to HSAG's receipt of the MMA plans' IDSS files, all of the MMA plans were required by AHCA to have their RY 2018 results examined and verified through an NCQA HEDIS Compliance Audit.[2-2] Additionally, the MMA plans supplied files with results for non-HEDIS performance measures (e.g., *Call Answer Timeliness*). The non-HEDIS performance measures results were also reviewed by an NCQA-certified auditor.

The LTC plan-specific performance displayed in this report was based on data elements obtained from performance measure files supplied by the LTC plans. Although all RY 2018 required measures for the LTC plans were AHCA-defined, the results were examined and verified based on NCQA's HEDIS Compliance Audit policies and procedures. Of note, the LTC plans reported the measure results using a custom rate template. Due to limitations of this template, HSAG was unable to distinguish the proportion of numerator events that were identified by medical record review (MRR) versus administrative data for hybrid measures. This issue has been corrected in the custom rate template for July 1, 2019, reporting.

Through the audit process, each measure indicator rate reported by a plan was assigned an NCQA-defined audit result. RY 2018 measure indicator rates received one of seven predefined audit results: *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR)*, *No Benefit (NB)*, *Not Required (NQ)*, *Unaudited (UN)*, and *Not Reported (NR)*. The audit results for the MMA and LTC plans are defined in appendices B and C, respectively.

Rates designated as *BR*, *NB*, *NQ*, *UN*, or *NR* are not presented in this report. All measure indicator rates that are presented in this report have been verified as an unbiased estimate of the measure. Please see appendices B and C for additional information on NCQA's Information System (IS) standards and the audit findings for the MMA and LTC plans.

[2-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2-2] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Calculation of Statewide Averages

For all measures, HSAG collected the audited results, numerator, denominator, rate, and eligible population elements reported in the files submitted by the plans to calculate the statewide average rate. Given that the plans varied in enrollee size, the statewide average rate was calculated for most of the measures based on the plans' eligible populations. Weighting the rates by the eligible population sizes ensured that the rate for a plan with 125,000 enrollees, for example, would have a greater impact on the overall statewide weighted average rate than the rate for a plan with only 10,000 enrollees. For plans' rates reported as *NA*, the numerators, denominators, and eligible populations were included in the calculations of the statewide average. Plan rates reported as *BR*, *NB*, *NQ*, *UN*, or *NR* were excluded from the statewide average calculation.

Evaluating Measure Results

National Benchmark Comparisons

Benchmark Data

RY 2018 MMA plan and statewide average rates, where available, were compared to the corresponding national HEDIS benchmarks, which are expressed in percentiles of national performance for different measures. For comparative purposes, HSAG used the most recent data available from NCQA at the time of the publication of this report to evaluate the HEDIS 2018 rates: NCQA's Quality Compass[2-3] national Medicaid All Lines of Business percentiles for HEDIS 2017, which are referred to as "national Medicaid percentiles" throughout this report. Of note, Quality Compass does not report benchmarks for the *Medication Management for People With Asthma—Medication Compliance 50%—Total*, *Follow-Up After ED Visit for Mental Illness*, or *Follow-Up After ED Visit for AOD Abuse or Dependence* measure indicators; therefore, NCQA's Audit Means and Percentiles national Medicaid HMO benchmarks for HEDIS 2017 were used. Additionally, current benchmarks are not available for the *Call Answer Timeliness* measure, as it was retired for HEDIS 2017; therefore, RY 2018 performance measure levels for this measure were compared to Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015 (the most recent year available).

Additionally, benchmarking data (i.e., NCQA's Quality Compass and NCQA's Audit Means and Percentiles) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays.

Figure Interpretation

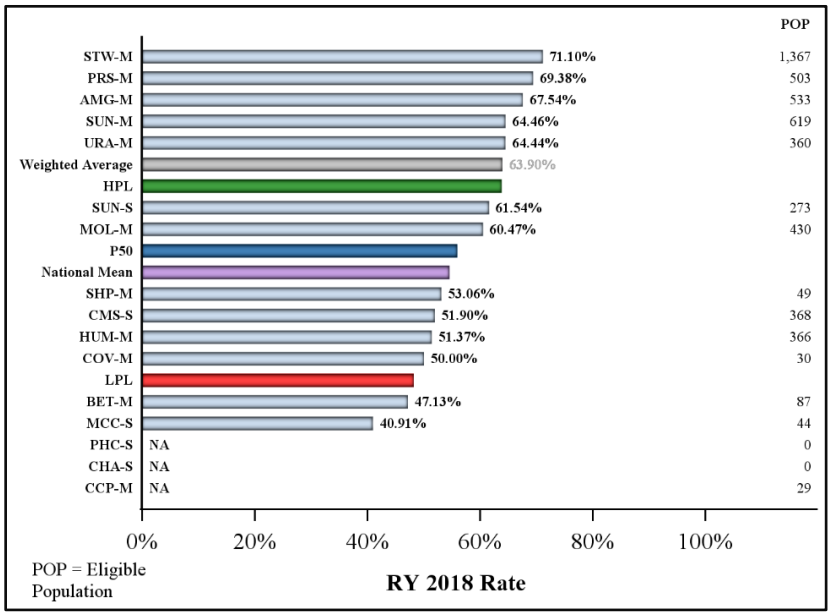
For each performance measure indicator presented in sections 3 through 8 of this report, the horizontal bar graph figure positioned on the right side of the page presents each MMA plan's performance against the RY 2018 statewide average (i.e., the gray shaded bar); the AHCA-defined performance target (i.e., the green shaded bar labeled high performance level [HPL]), representing the national Medicaid 75th percentile; the P50 bar (i.e., the blue shaded bar), representing the national Medicaid 50th percentile; the

[2-3] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

national Medicaid mean (i.e., the purple shaded bar); and the low performance level (LPL) (i.e., the red shaded bar), representing the national Medicaid 25th percentile.

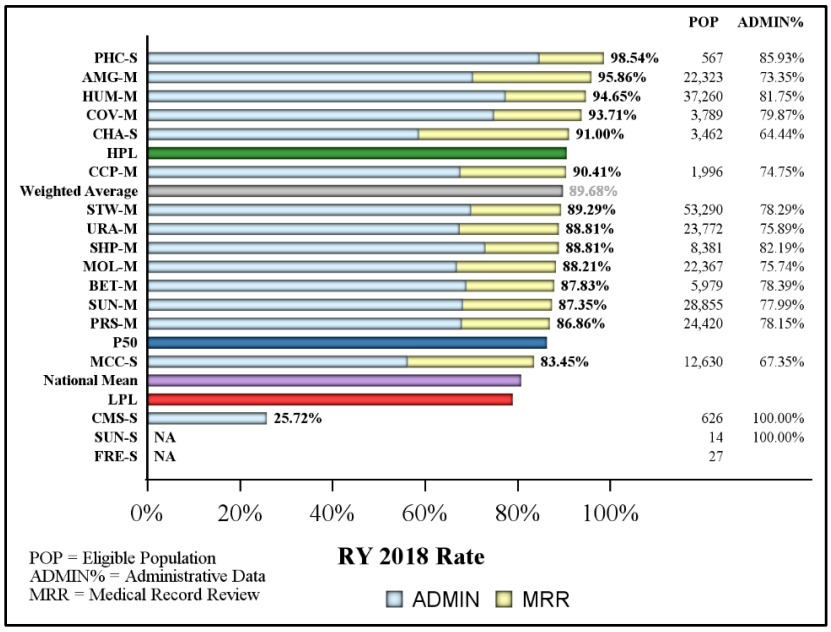
For measures for which lower rates indicate better performance, the 25th percentile (rather than the 75th percentile) and the 75th percentile (rather than the 25th percentile) are considered the HPL and LPL, respectively. An example of the horizontal bar graph figure for measure indicators reported administratively is shown below in Figure 9-2.

Figure 9-2—Sample Horizontal Bar Graph Figure for Administrative Measures



For performance measure rates that were reported using the hybrid method, the "ADMIN%" column presented with each horizontal bar graph figure displays the percentage of the rate derived from administrative data (e.g., claims data and supplemental data). The portion of the bar shaded yellow represents the proportion of the total measure rate attributed to medical record review, while the portion of the bar shaded light blue indicates the proportion of the measure rate that was derived using the administrative method. This percentage describes the level of claims/encounter data completeness of the MMA plan's data for calculating a particular performance measure. A low administrative data percentage suggests that the MMA plan relied heavily on medical records to report the rate. Conversely, a high administrative data percentage indicates that the MMA plan's claims/encounter data were relatively complete for use in calculating the performance measure indicator rate. An administrative percentage of 100 percent indicates that either the MMA plan identified all numerator events for that measure using administrative data or that the MMA plan did not report the measure indicator rate using the hybrid method. An example of the horizontal bar graph figure for measure indicators reported using the hybrid method is shown in Figure 9-3.

Figure 9-3—Sample Horizontal Bar Graph Figure for Hybrid Measures



Percentile Rankings and Star Ratings

In addition to illustrating MMA plan and statewide performance via side-by-side comparisons to national percentiles, benchmark comparisons are denoted in Appendix D of this report using the percentile ranking performance levels and star ratings defined below in Table 9-4.

Table 9-4—Percentile Ranking Performance Levels

Star Rating	Performance Level
□□□□□	At or above the national Medicaid 90th percentile
□□□□	At or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile
□□□	At or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile
□□	At or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile
□	Below the national Medicaid 25th percentile
NA	NA indicates that the MMA plan followed the specifications, but the denominator was too small to report a valid rate.
NB	NB indicates that the required benefit to calculate the measure was not offered.

With the exception of *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, measures in the Use of Services domain are designed to capture the frequency of services provided, and higher or lower rates do not necessarily indicate better or worse performance.

For the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure, HSAG inverted the star ratings to be consistently applied to this measure as with the other RY measures. For example, the 10th percentile (a lower rate) was inverted to become the 90th percentile, indicating better performance.

Of note, MMA plan and statewide average rates were rounded to the second decimal place before performance levels were determined. As HSAG assigned star ratings, NC (not comparable) was presented to indicate that a performance level was not presented in this report either because the measure did not have an applicable benchmark or a comparison to benchmarks was not appropriate.

Performance Trend Analysis

HSAG compared RY 2018 statewide average and plan rates to the corresponding RY 2017 rates, where applicable. HSAG also evaluated the extent of changes observed in the rates between years. Year-over-year performance comparisons are based on the Chi-square test of statistical significance with a *p*-value <0.05 for plan rate comparisons and a *p*-value <0.01 for statewide average rate comparisons. Note that statistical testing could not be performed on the utilization-based measures domain given that variances were not available in the IDSS files for HSAG to use for statistical testing.

In general, results from statistical significance testing provide information on whether a change in the rate may suggest improvement or decline in performance. In the analysis of each domain and measure-specific findings there are references to "significant" changes in performance are noted; these instances refer to statistically significant differences between performance from RY 2017 to RY 2018. At the statewide level, if the number of plans reporting *NR* or *BR* differs vastly from year to year, the statewide performance may not represent all of the contracted plans, and any changes of *NR* and *BR* observed in the previous years and current year would impact changes seen at the statewide level. Nonetheless, changes (regardless of whether they are statistically significant) could be related to the following factors independent of any effective interventions designed to improve the quality of care:

- Substantial changes in measure specifications. The "Measure Changes Between RY 2017 and RY 2018" section below lists measures with specification changes made by NCQA.
- Substantial changes in enrollment composition within the plan.

Table and Figure Interpretation

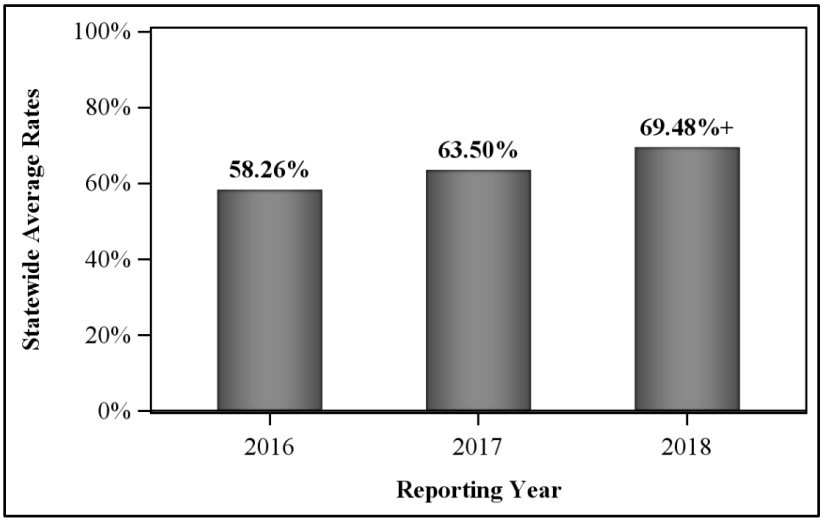
Within sections 3 through 9 of this report, performance measure indicator rates and results of significance testing between RY 2017 and RY 2018 are presented in tabular format, where available. RY 2018 rates shaded green with one cross (+) indicate a statistically significant improvement in performance from the previous year. RY 2018 rates shaded red with two crosses (++) indicate a statistically significant decline in performance from the previous year. The colors used are provided below for reference:

Green Shading +	*Indicates that the RY 2018 statewide average demonstrated a statistically significant improvement from the RY 2017 statewide average.*
Red Shading ++	*Indicates that the RY 2018 statewide average demonstrated a statistically significant decline from the RY 2017 statewide average.*

Additionally, benchmark comparisons are denoted within sections 3 through 9, where available.

For each performance measure indicator presented in sections 3 through 9 of this report, where applicable, the vertical bar graph figure positioned on the left side of the page presents the RY 2016, RY 2017, and RY 2018 statewide averages with significance testing performed between the RY 2017 and RY 2018 statewide averages. Within these figures, RY 2018 rates with one cross (+) indicate a statistically significant improvement in performance from RY 2017. RY 2018 rates with two crosses (++) indicate a statistically significant decline in performance from RY 2017. An example of the vertical bar graph figure for measure indicators reported is included in Figure 9-4.

Figure 9-4—Sample Vertical Bar Graph Figure Showing Statistically Significant Improvement



Interpreting Results Presented in This Report

As expected, performance results can differ to a greater or lesser extent among plans and even across measures for the same plan.

How accurate are the results?

AHCA required all Florida MMA plans and LTC plans to have their performance measure results confirmed by an NCQA HEDIS Compliance Audit to ensure that all measures reported followed HEDIS and AHCA requirements. As a result, any rate included in this report has been verified as an unbiased estimate of the measure. NCQA's HEDIS protocol is designed so that the hybrid methodology produces results with a sampling error of ± 5 percentage points at a 95 percent confidence level. How sampling error affects the accuracy of results is best explained using an example. Suppose that a plan used the hybrid method to derive a *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* rate of 52 percent. Because of sampling error, the true rate would actually be within ± 5 percentage points of this—somewhere between 47 percent and 57 percent at a 95 percent confidence level. If the target is a rate of 55 percent, it cannot be said with certainty whether the true rate between 47 percent and 57 percent meets or does not meet the target level.

To prevent such ambiguity, this report uses a standardized methodology that requires the reported rate to be at or above the threshold level to be considered as meeting the target. For internal purposes, plans should understand the sampling error concept and consider this when implementing interventions.

How do Florida Medicaid plan rates compare to AHCA performance targets and national percentiles?

For each measure, a plan-ranking figure presents the reported rates from highest to lowest, with bars representing the AHCA performance target (i.e., the national Medicaid 75th percentile) along with the national Medicaid 25th and 50th percentiles and the national Medicaid mean. In addition, the statewide weighted average is provided for comparative purposes.

MMA plans with reported rates above the 75th percentile rank in the top 25 percent of all Medicaid health plans nationally. Conversely, MMA plans falling below the 25th percentile rank in the bottom 25 percent nationally.

Measure Changes

With the release of HEDIS 2018, NCQA and AHCA updated specifications for some measures included in this report, which may have impacted trending and/or comparisons to national data. The following are measures included in this report along with descriptions of measure specification changes made to each measure that NCQA or AHCA announced for RY 2018, when applicable.[2-4, 2-5] Measures reported for the first time for HEDIS 2018 are not included in this section. Measures are organized by domain.

Pediatric Care

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

- Added telehealth as eligible for one visit for the continuation and maintenance (C&M) phase.

[2-4] National Committee for Quality Assurance. *HEDIS® 2018, Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA; 2016.

[2-5] National Committee for Quality Assurance. *HEDIS® 2018, Volume 2: Technical Update*. Washington, DC: NCQA; 2016.

- Clarified that for the C&M phase, visits must be on different dates of service.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

- Clarified that the pregnancy optional exclusion should be applied to only female enrollees.
- Clarified in the notes that documentation related to an enrollee's "appetite" does not meet criteria for counseling for nutrition.
- Revised the Data Elements for Reporting table to reflect removal of the Final Sample Size (FSS) when reporting using the hybrid methodology.

Immunizations for Adolescents (IMA)

- Added a two-dose human papillomavirus (HPV) vaccination series.
- Revised the Data Elements for Reporting table to reflect removal of the FSS when reporting using the hybrid methodology.

Annual Dental Visit (ADV)

- Removed codes/value sets from the measure.

Women's Care

Breast Cancer Screening (BCS)

- Added digital breast tomosynthesis as a method for meeting numerator criteria.

Prenatal and Postpartum Care (PPC)

- Updated the administrative numerator specification to indicate when codes must be on the same claim and when codes can occur on different dates of service.

Living With Illness

Comprehensive Diabetes Care (CDC)

- Added bilateral eye enucleation to the *Eye Exam (Retinal) Performed* indicator.
- Revised the language in step 1 of the BP Control <140/90 mm Hg numerator and added notes clarifying the intent when excluding BP readings from the numerator.
- Clarified the medical record requirements for evidence of ACE inhibitor/ARB therapy (for the *Medical Attention for Nephropathy* indicator).
- Added "sacubitril-valsartan" to the description of antihypertensive combinations in the ACE Inhibitor/ARB Medications List.

Controlling High Blood Pressure (CBP)

- Clarified that a diagnosis code for hypertension documented in the medical record may be used to confirm the diagnosis of hypertension.
- Clarified that the pregnancy optional exclusion should be applied to only female enrollees.
- Revised the language in step 1 of the numerator and added notes clarifying the intent when excluding BP readings from the numerator.

Adult BMI Assessment (ABA)

- Clarified that the pregnancy optional exclusion should be applied to only female enrollees.

Annual Monitoring for Patients on Persistent Medications (MPM)

- Added "sacubitril-valsartan" to the description of antihypertensive combinations in the ACE Inhibitor/ARB Medications List.

Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

- This measure is collected using survey methodology. Detailed specifications and summary of changes are contained in *HEDIS 2018, Volume 3: Specifications for Survey Measures*.

Care for Older Adults (COA)

- Clarified that codes must be on the same claim for the *Medication Review* indicator (Administrative Specification).
- Added the continence activities of daily living (ADL) to the list of acceptable ADLs for medical record documentation of the *Functional Status Assessment* numerator.
- Clarified that notation alone that cranial nerves were assessed does not meet criteria for the sensory ability component for the *Functional Status Assessment* numerator.
- Clarified the requirements for the speech component (sensory ability) for the *Functional Status Assessment* numerator.

Behavioral Health

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

- Added pharmacy benefit.
- Added reporting for indicators by age and diagnosis.
- Clarified that for ED visits resulting in an inpatient stay, an AOD diagnosis is not required for the stay when identifying the index episode start date (IESD).
- Clarified that a direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less.
- Clarified how to identify an ED visit that resulted in an inpatient stay.
- Added dispensing of medication-assisted treatment.
- Added "telehealth" to the denominator and numerators.
- Removed the note about detoxification from the numerator statement.
- Extended the *Engagement of AOD Treatment* time frame to 34 days from 30 days.

Follow-up After Hospitalization for Mental Illness (FHM)

- Revised the measure to no longer include visits that occur on the date of discharge.
- Added telehealth modifiers to the numerators.

Antidepressant Medication Management (AMM)

- Added telehealth modifiers and telephone visits to the required exclusions (step 2).

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

- Added telehealth modifiers to the required exclusions (step 4).

Use of Services

Ambulatory Care (AMB)

- Clarified how to identify an ED visit that resulted in an inpatient stay.
- Removed the AOD Rehab and Detox Value Set from the required exclusions (exclusions will be identified based on a principal diagnosis of chemical dependency).
- Revised the data elements tables to indicate that rates are calculated for the *Visits/1,000 Member Months/Years* in the unknown category.

Long-Term Care Performance Measures

Required Record Documentation (RRD)

- New specifications have been added for the eligible population for Numerators One and Five.
- Added a note that exclusions should be made prior to identifying the eligible population.
- New exclusions have been added for Numerators One and Six.
- Changed the first year of reporting for Numerator Six from July 1, 2018 to July 1, 2019.

Timeliness of Services (TOS)

- Changed the collection method to administrative or hybrid.
- Added additional information to the eligible population.

10. Pediatric Care

Introduction

The Pediatric Care measure domain encompasses the following measures reported by the Standard and Specialty MMA plans:

- *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Childhood Immunization Status—Combinations 2* and *3*
- *Lead Screening in Children*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
- *Adolescent Well-Care Visits*
- *Immunizations for Adolescents—Combinations 1* and *2*
- *Annual Dental Visit—Total*
- *Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented in this section. For reference, additional analyses for each measure indicator are displayed in Appendix D.

Summary of Findings

Table 10-1 presents the statewide average performance for the measure indicators under the Pediatric Care measure domain. The table lists the RY 2018 statewide average and performance levels, a comparison of the RY 2017 to the RY 2018 statewide average for each measure indicator with trend analysis results, and a summary of the MMA plans with rates demonstrating statistically significant changes from RY 2017 to RY 2018.

Table 10-1—RY 2018 Statewide Performance Levels and Trend Results for Pediatric Care

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of MMA Plans With Statistically Significant Improvement in RY 2018	Number of MMA Plans With Statistically Significant Decline in RY 2018
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	1.97%	0.00	0	1
Six or More Well-Child Visits	69.48%	**+5.98⁺**	5	0
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.94%	**+2.28⁺**	6	0
Childhood Immunization Status				
Combination 2	78.16%	-0.05	0	0
Combination 3	73.71%	**-0.51⁺⁺**	1	0
Lead Screening in Children				
Lead Screening in Children	67.48%	**+1.63⁺**	3	0
Follow-Up Care for Children Prescribed ADHD Medication[3]				
Initiation Phase	48.22%	-0.33	4	3
Continuation and Maintenance Phase	63.90%	-1.19	3	2
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	82.76%	**+4.36⁺**	10	1
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	57.22%	**+4.31⁺**	3	0
Immunizations for Adolescents				
Combination 1	71.93%	**+1.31⁺**	2	0
Combination 2[4]	30.45%	NC	NC	NC
Annual Dental Visit				
Total	50.87%	**+2.32⁺**	14	0
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk				
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	28.26%	**-2.15⁺⁺**	1	4

[1] 2018 performance levels were based on comparisons of the RY 2018 statewide average measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks. 2018 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] RY 2017 statewide average to RY 2018 statewide average comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

[3] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.

[4] *Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between 2018 and prior years; therefore, comparisons to the prior year's rates and benchmarks are not performed for this measure.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*

Green Shading[+]	*Indicates that the RY 2018 statewide average demonstrated a statistically significant improvement from the RY 2017 statewide average.*
Red Shading[++]	*Indicates that the RY 2018 statewide average demonstrated a statistically significant decline from the RY 2017 statewide average.*

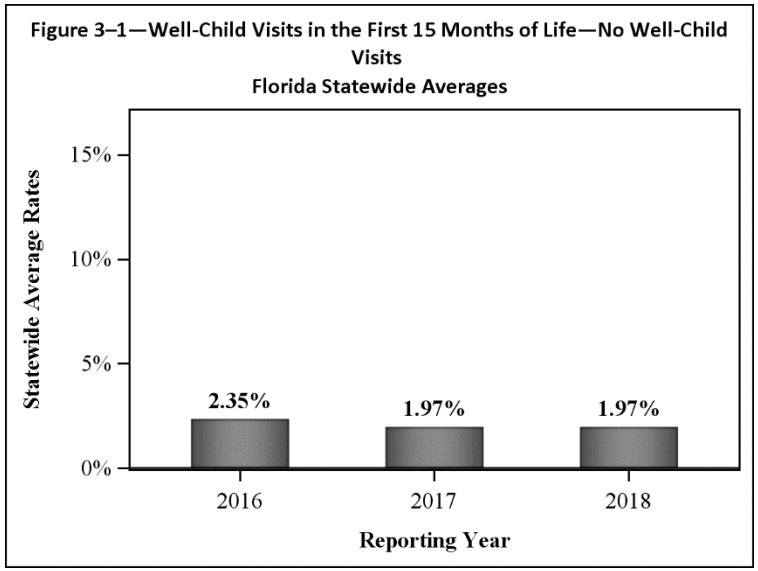
Table 3-1 shows that for the Pediatric Care domain, seven of 13 statewide average rates (approximately 54 percent) that could be compared to the prior year's rates demonstrated significant increases from RY 2017 to RY 2018. Additionally, three of 12 statewide average rates (approximately 25 percent) were at or above the national Medicaid 75th percentile. Of note, the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measures were areas of strength in this domain, as the statewide averages for these measures were both above the national Medicaid 75th percentile and demonstrated significant increases.

Conversely, four of 12 statewide average rates (approximately 33 percent) fell below the national Medicaid 50th percentile; however, three of these rates demonstrated significant increases from RY 2017 to RY 2018. Of note, although the statewide average for *Annual Dental Visit—Total* fell below the 50th percentile, 14 MMA plans demonstrated significant increases in RY 2018 for this measure. Additionally, the statewide average rate for *Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk* demonstrated a significant decline from RY 2017 to RY 2018, further demonstrating opportunities to improve care for children.

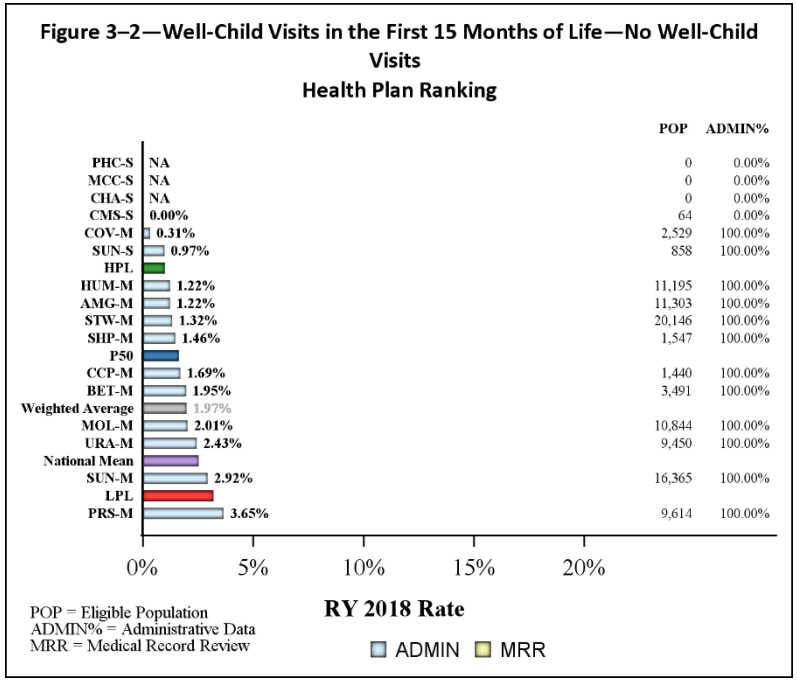
Measure-Specific Findings

Well-Child Visits in the First 15 Months of Life—No Well-Child Visits

Well-Child Visits in the First 15 Months of Life—No Well-Child Visits assesses the percentage of enrollees who turned 15 months old during the measurement year and who did not receive any well-child visits with a PCP during their first 15 months of life. For this indicator, a lower rate indicates better performance.



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.



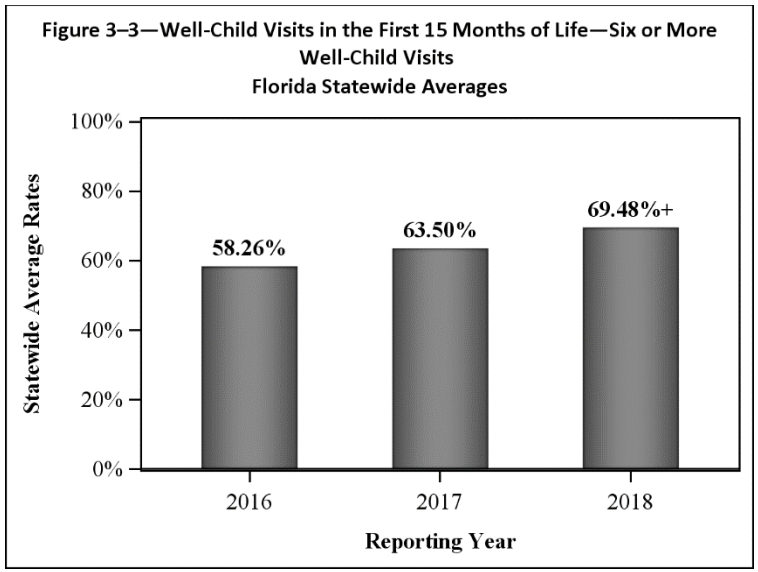
NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.

Seven MMA plans with reportable rates ranked above the national Medicaid 50th percentile, with three MMA plans ranking above the HPL. One MMA plan fell below the LPL. MMA plan performance varied by over 3 percentage points.

Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits

Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits assesses the percentage of enrollees who turned 15 months old during the measurement year and who received six or more well-child visits with a PCP during their first 15 months of life.

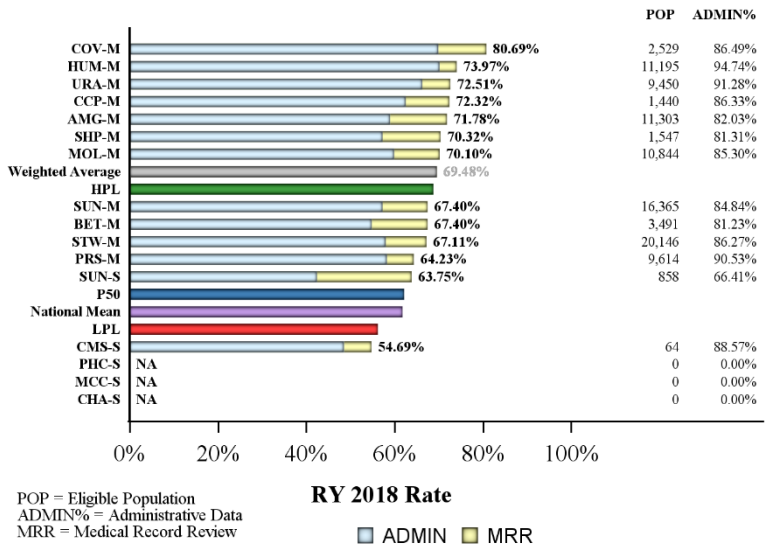
Figure 3–3—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 3–4—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits
Health Plan Ranking



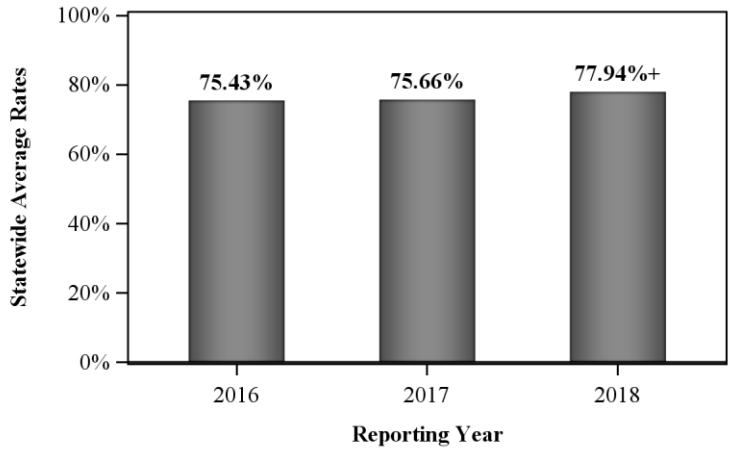
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Twelve MMA plans ranked above the national Medicaid 50th percentile, with seven MMA plans and the statewide average ranking above the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by over 25 percentage points.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life is a measure of the percentage of enrollees who were 3, 4, 5, or 6 years old and received one or more well-child visits with a PCP during the measurement year.

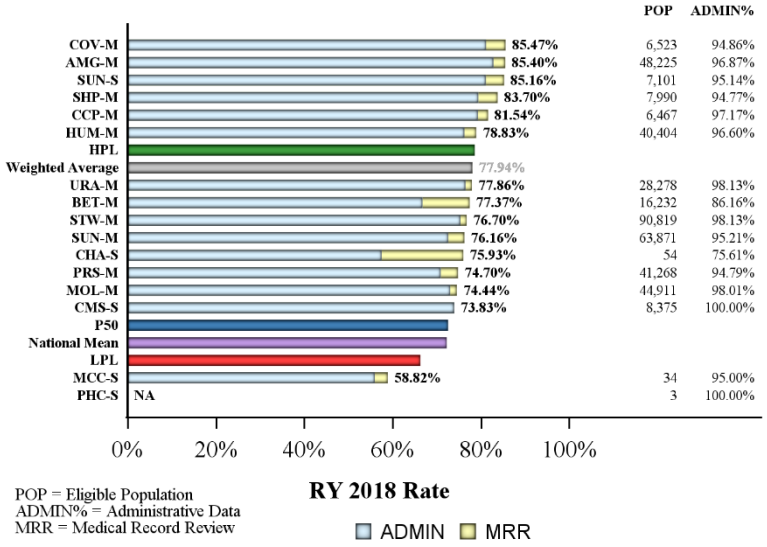
Figure 3–5—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 3–6—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Health Plan Ranking

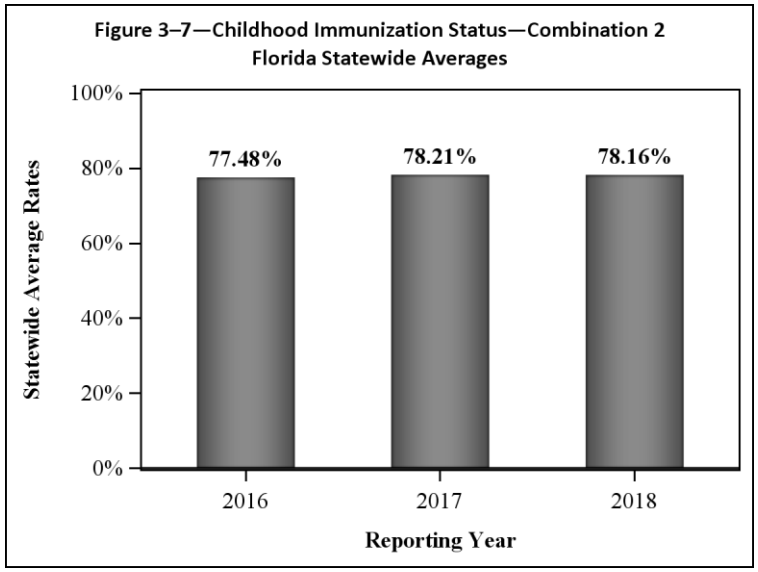


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

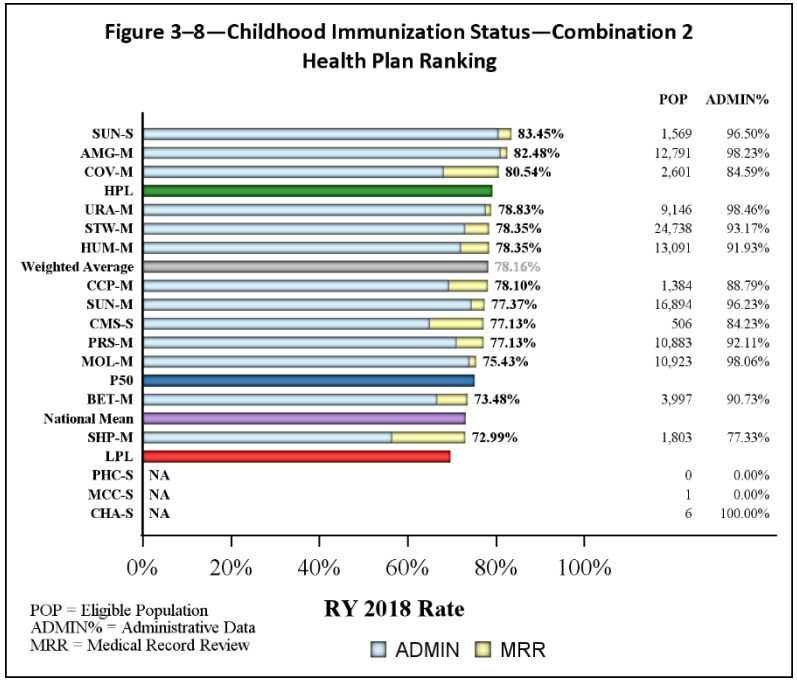
Fourteen MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with six MMA plans ranking above the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by over 25 percentage points.

Childhood Immunization Status—Combination 2

Childhood Immunization Status—Combination 2 assesses the percentage of children 2 years of age who received the following vaccines by their second birthday: four diphtheria, tetanus, and acellular pertussis; three polio; one measles, mumps, and rubella; three haemophilus influenzae type B; three hepatitis B; and one chicken pox.



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

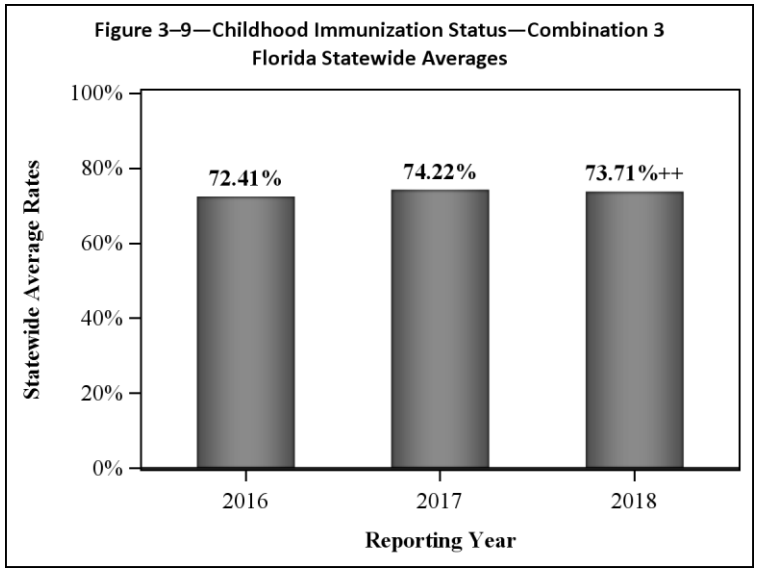


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Eleven MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with three MMA plans ranking above the HPL. No MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 10 percentage points.

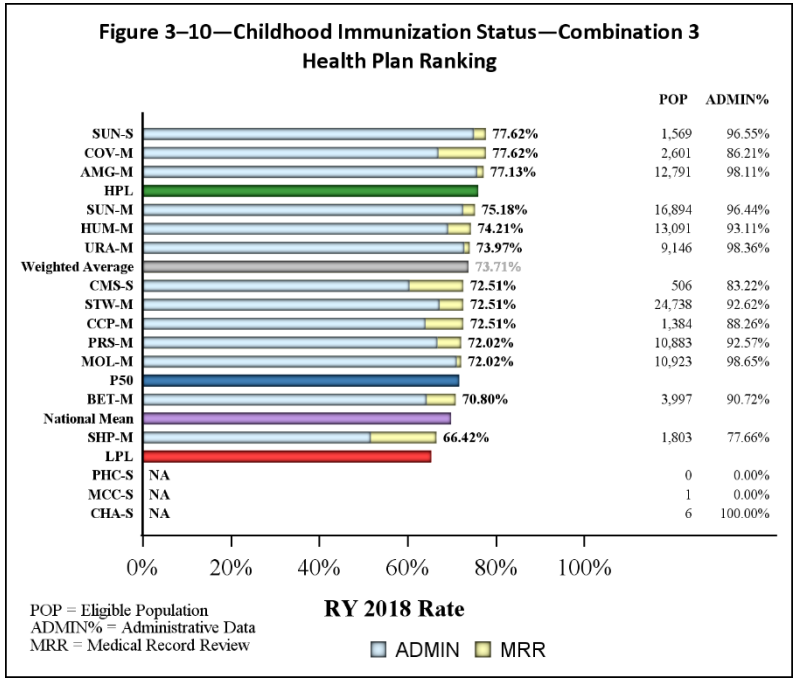
Childhood Immunization Status—Combination 3

Childhood Immunization Status—Combination 3 assesses the percentage of children 2 years of age during the measurement year who received the following vaccines by their second birthday: four diphtheria, tetanus, and acellular pertussis; three polio; one measles, mumps, and rubella; three haemophilus influenzae type B; three hepatitis B; one chicken pox; and four pneumococcal conjugate.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

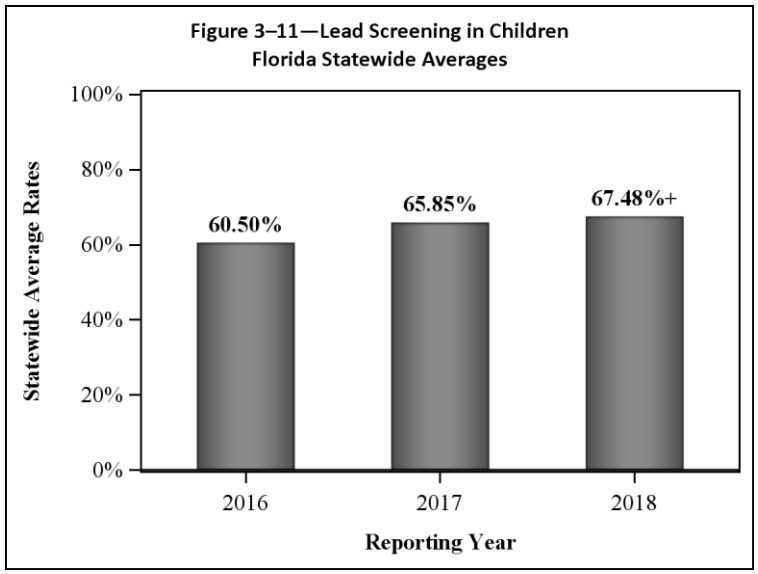


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Eleven MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with three MMA plans ranking above the HPL. No MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 10 percentage points.

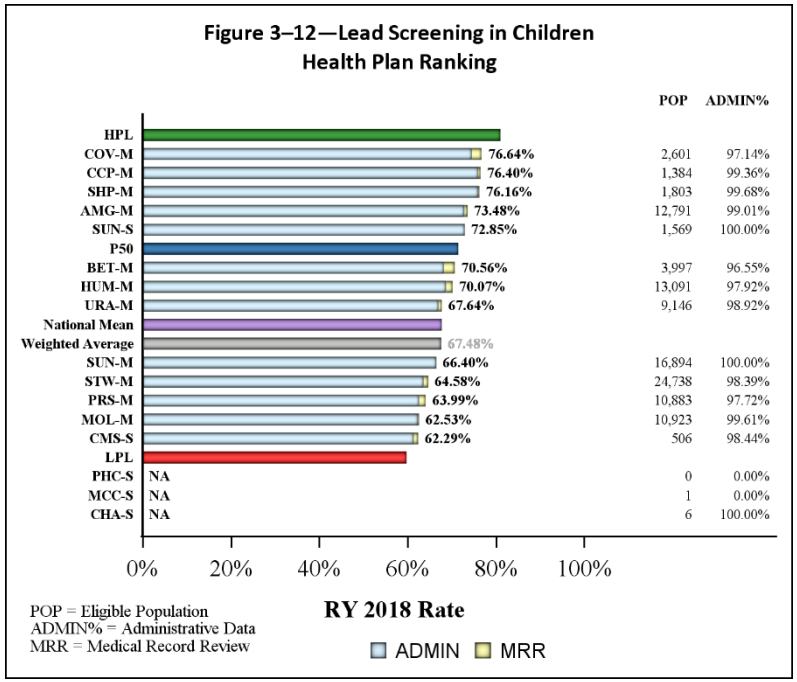
Lead Screening in Children

Lead Screening in Children assesses the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



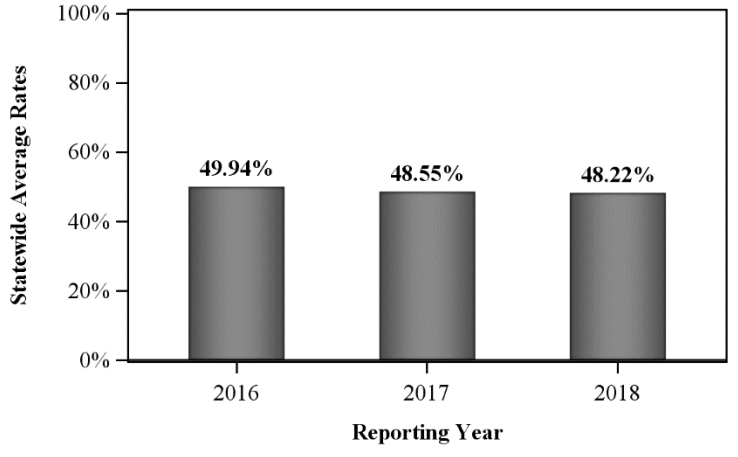
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Five MMA plans ranked above the national Medicaid 50th percentile. No MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 10 percentage points.

Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase

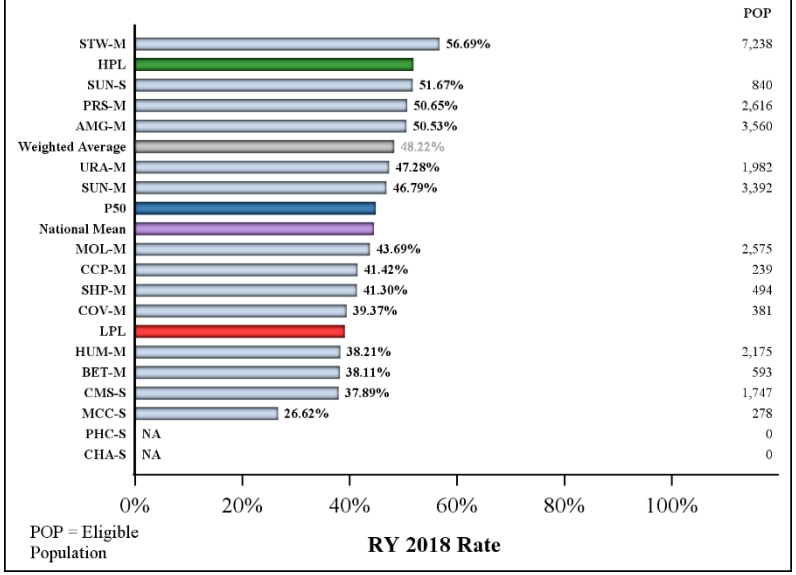
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase assesses the percentage of children 6 to 12 years of age who were newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication and who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.

Figure 3–13—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase
Florida Statewide Averages



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

Figure 3–14—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase
Health Plan Ranking



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

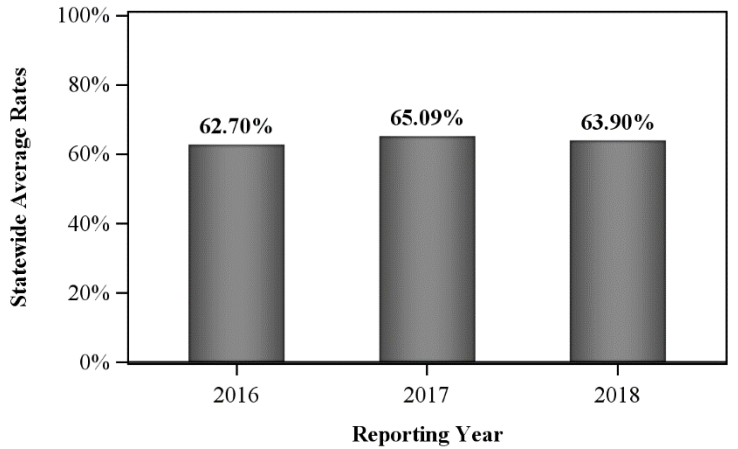
Six MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with one MMA plan ranking above the HPL. Four MMA plans with reportable

rates fell below the LPL. MMA plan performance varied by over 30 percentage points.

Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase

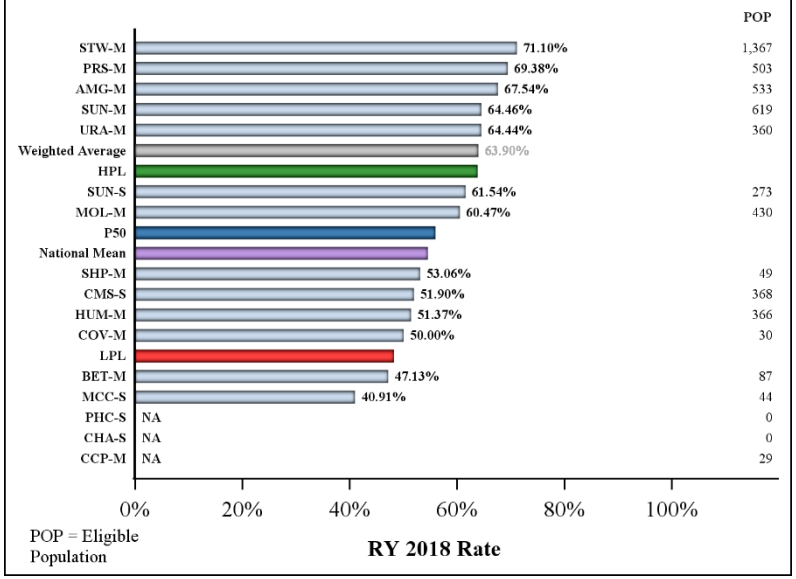
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase assesses the percentage of children 6 to 12 years of age newly prescribed ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the initiation phase ended. Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.

Figure 3–15—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase
Florida Statewide Averages



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

Figure 3–16—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase
Health Plan Ranking



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

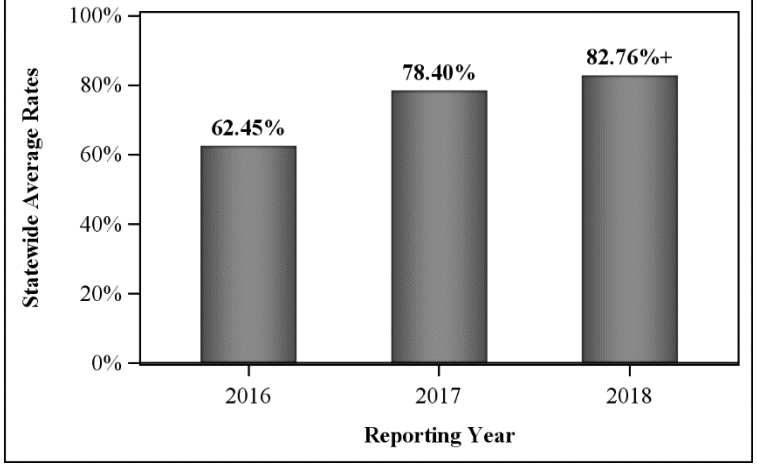
Seven MMA plans ranked above the national Medicaid 50th percentile, with five MMA plans and the statewide

average ranking above the HPL. Two MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 30 percentage points.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total assesses the percentage of enrollees 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year.

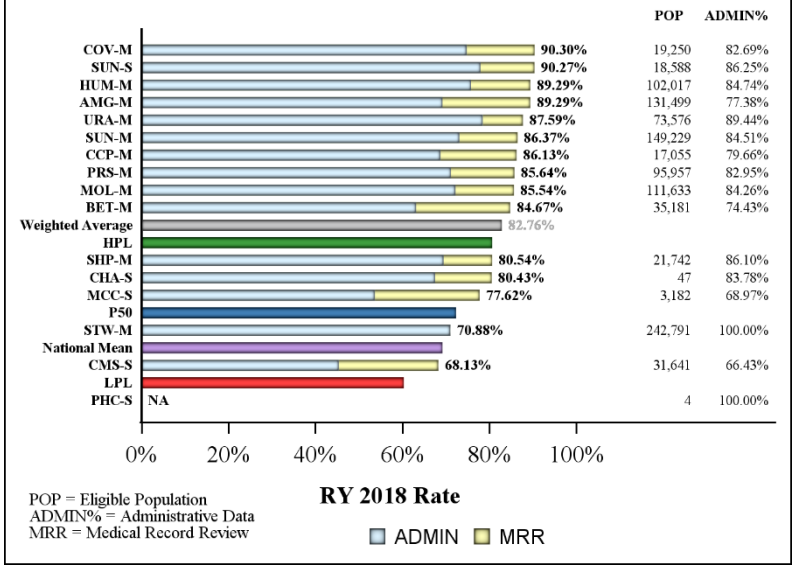
Figure 3–17—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 3–18—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total Health Plan Ranking



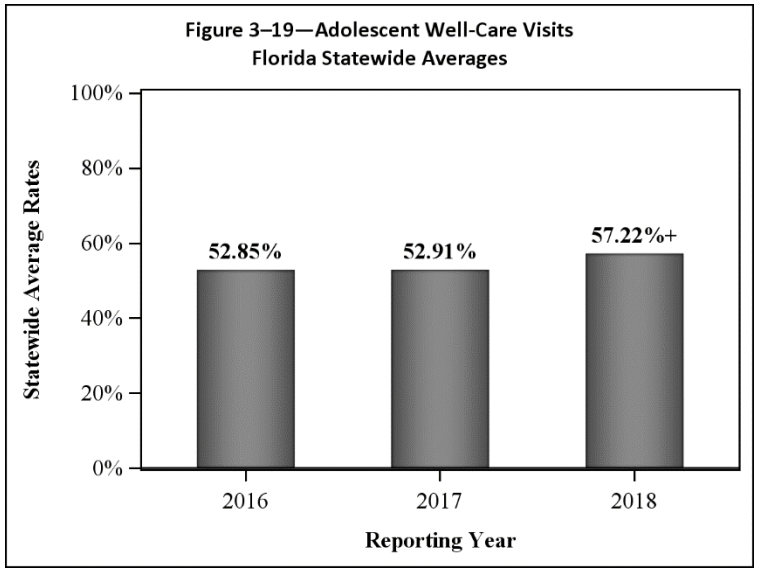
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Thirteen MMA plans ranked above the national Medicaid 50th percentile, with 10 MMA plans and the statewide

average ranking above the HPL. No MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 20 percentage points.

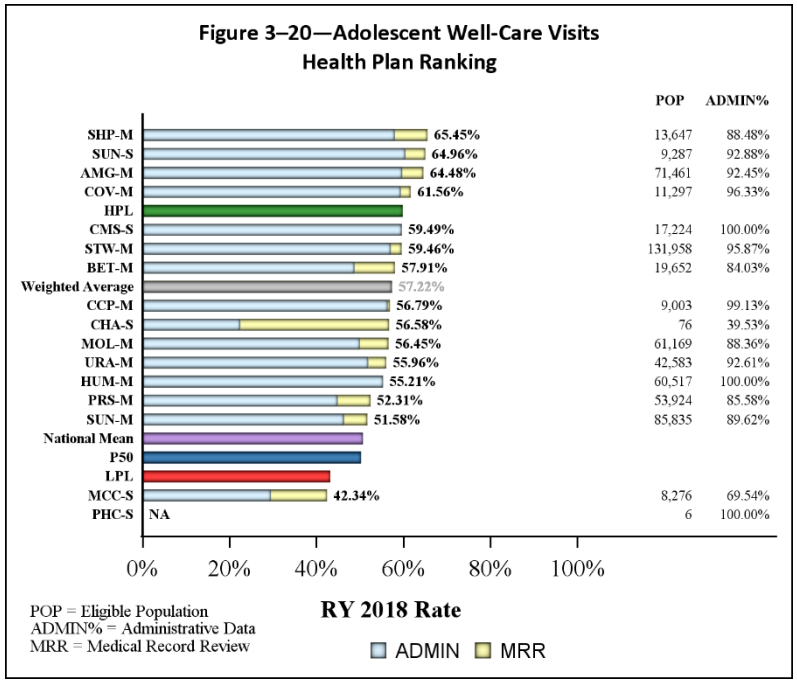
Adolescent Well-Care Visits

Adolescent Well-Care Visits assesses the percentage of enrollees who were 12 to 21 years of age and who had at least one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



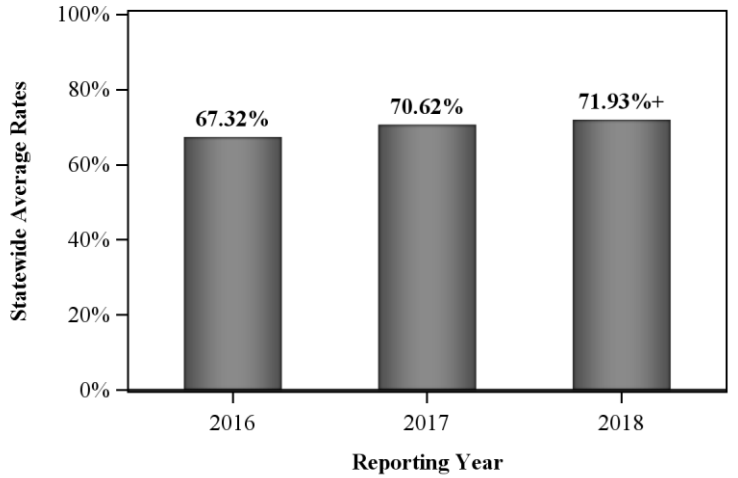
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Fourteen MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with four MMA plans ranking above the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by over 20 percentage points.

Immunizations for Adolescents—Combination 1

Immunizations for Adolescents—Combination 1 assesses the percentage of adolescents 13 years of age who had the following by their 13th birthday: one dose of meningococcal vaccine and acellular pertussis vaccine (Tdap).

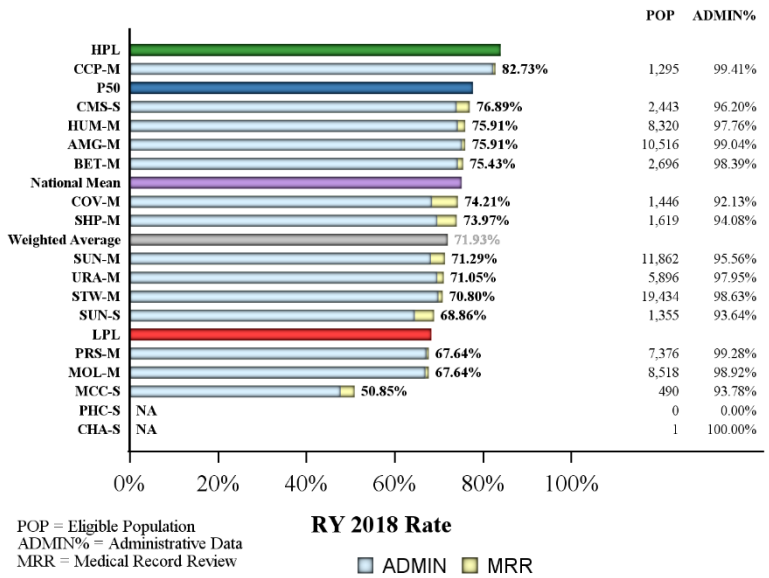
Figure 3–21—Immunizations for Adolescents—Combination 1
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 3–22—Immunizations for Adolescents—Combination 1
Health Plan Ranking



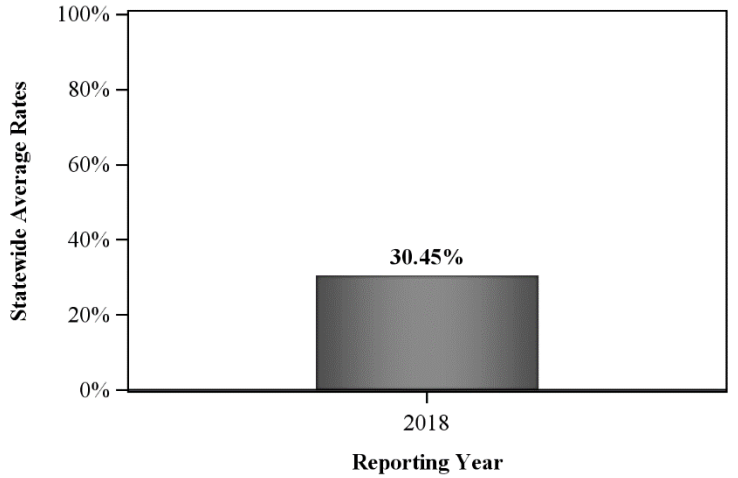
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MMA plan ranked above the national Medicaid 50th percentile. Three MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 30 percentage points.

Immunizations for Adolescents—Combination 2

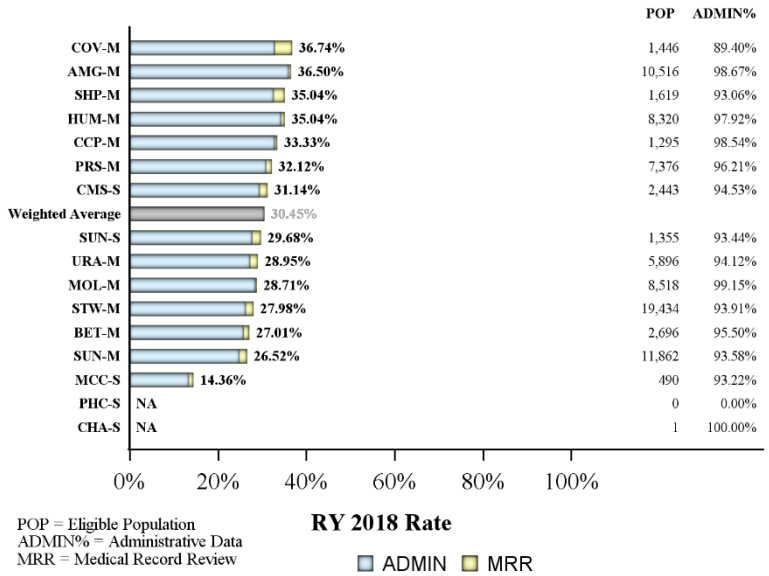
Immunizations for Adolescents—Combination 2 measures the percentage of enrollees 13 years of age who had the following vaccines by their 13th birthday: one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and completed the HPV vaccine series.

Figure 3–23—Immunizations for Adolescents—Combination 2
Florida Statewide Averages



Due to changes to the RY 2018 technical specifications for this measure indicator, NCQA does not recommend trending between 2018 and prior years; therefore, prior year statewide average rates are not displayed.

Figure 3–24—Immunizations for Adolescents—Combination 2
Health Plan Ranking

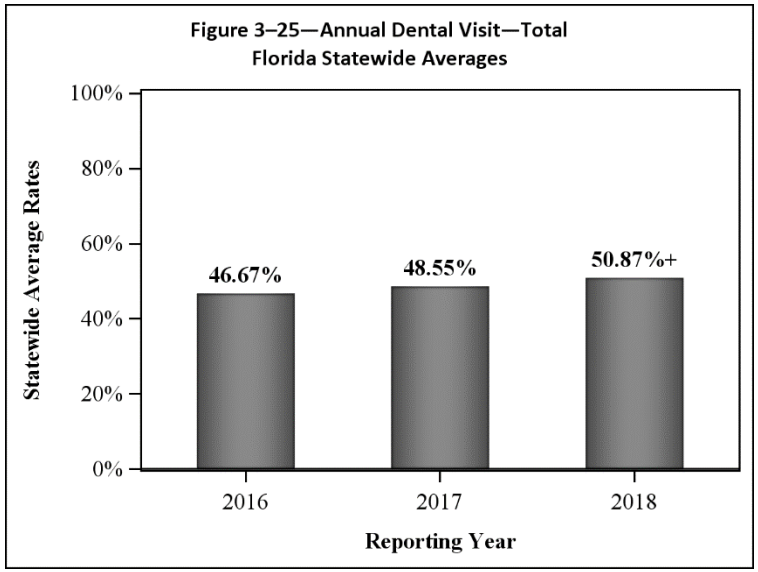


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Due to changes in the technical specifications in RY 2018 for this measure, a comparison to benchmarks is not appropriate. The rates in the chart above are presented for information only. MMA plan performance varied by over 20 percentage points.

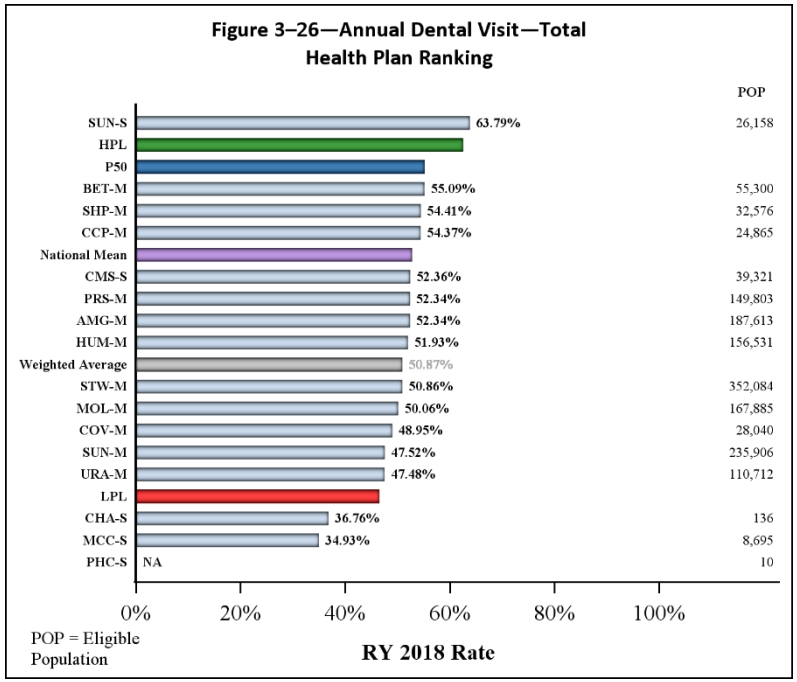
Annual Dental Visit—Total

Annual Dental Visit—Total measures the percentage of enrollees 2 to 20 years of age who had at least one dental visit during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



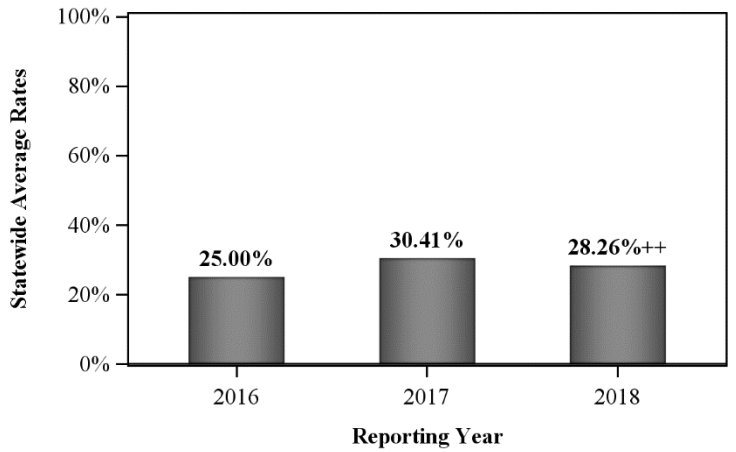
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MMA plan ranked above the national Medicaid 50th percentile and above the HPL. Two MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 25 percentage points.

Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk

Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk measure represents the percentage of enrollees 6 to 9 years of age at elevated risk of dental caries (i.e., "moderate" or "high" risk) who received a sealant on a permanent first molar tooth within the measurement year.

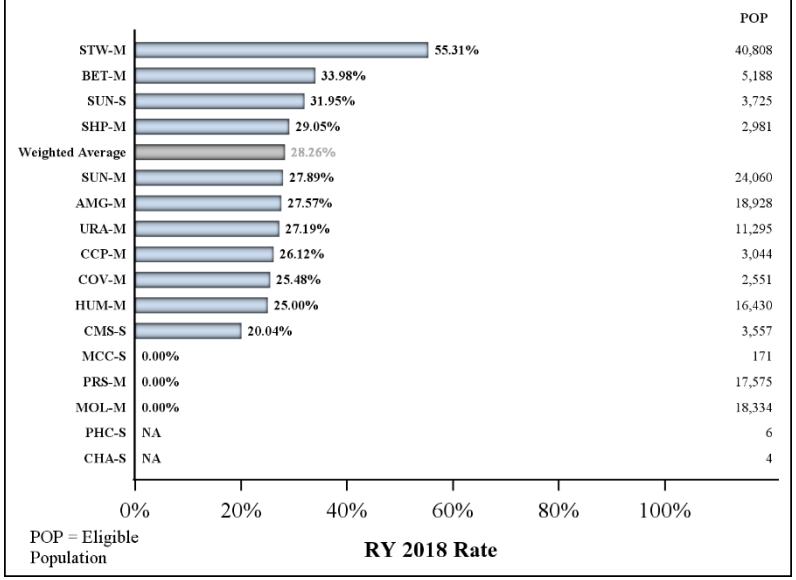
Figure 3–27—Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk
Florida Statewide Averages



Due to issues associated with the plan-level eligible population values for this measure, the 2016 statewide average was weighted by select plans' denominators rather than by the eligible populations; therefore, caution should be exercised when comparing the 2016 statewide average to other years' rates.
Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

Figure 3–28—Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk
Health Plan Ranking



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by over 55 percentage points.

Introduction

The Women's Care measure domain encompasses the following measures reported by the Standard and Specialty MMA plans:

- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Breast Cancer Screening*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Contraceptive Care—Postpartum Women—Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery* and *Within 60 Days of Delivery* and *Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery* and *Within 60 Days of Delivery*
- *Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery* and *Within 60 Days of Delivery* and *Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery* and *Within 60 Days of Delivery*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented in this section. For reference, additional analyses for each measure indicator are displayed in Appendix D.

Summary of Findings

Table 11-1 presents the statewide average performance for the measure indicators under the Women's Care measure domain. The table lists the RY 2018 statewide average and performance levels, a comparison of the RY 2017 to the RY 2018 statewide average for each measure indicator with trend analysis results, and a summary of the MMA plans with rates demonstrating statistically significant changes from RY 2017 to RY 2018.

Table 11-1—RY 2018 Statewide Performance Levels and Trend Results for Women's Care

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of MMA Plans With Statistically Significant Improvement in RY 2018	Number of MMA Plans With Statistically Significant Decline in RY 2018
Cervical Cancer Screening				
Cervical Cancer Screening	59.84%	+3.76+	2	0
Chlamydia Screening in Women				

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of MMA Plans With Statistically Significant Improvement in RY 2018	Number of MMA Plans With Statistically Significant Decline in RY 2018
Total	64.31%	+1.76+	7	0
Breast Cancer Screening[3]				
Breast Cancer Screening	58.17%	NC	NC	NC
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.93%	-2.33++	1	2
Postpartum Care	64.54%	+0.99+	3	0
Contraceptive Care—Postpartum Women				
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	1.00%	NC	NC	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	35.57%	NC	NC	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.03%	NC	NC	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	7.40%	NC	NC	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	10.83%	NC	NC	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	39.41%	NC	NC	NC

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of MMA Plans With Statistically Significant Improvement in RY 2018	Number of MMA Plans With Statistically Significant Decline in RY 2018
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.05%	NC	NC	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	6.65%	NC	NC	NC

[1] 2018 performance levels were based on comparisons of the RY 2018 statewide average measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks. 2018 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] RY 2017 statewide average to RY 2018 statewide average comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

[3] Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between 2018 and prior years; therefore, comparisons to the prior year's rates and benchmarks are not performed for this measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

Green Shading[+] *Indicates that the RY 2018 statewide average demonstrated a statistically significant improvement from the RY 2017 statewide average.*

Red Shading[++] *Indicates that the RY 2018 statewide average demonstrated a statistically significant decline from the RY 2017 statewide average.*

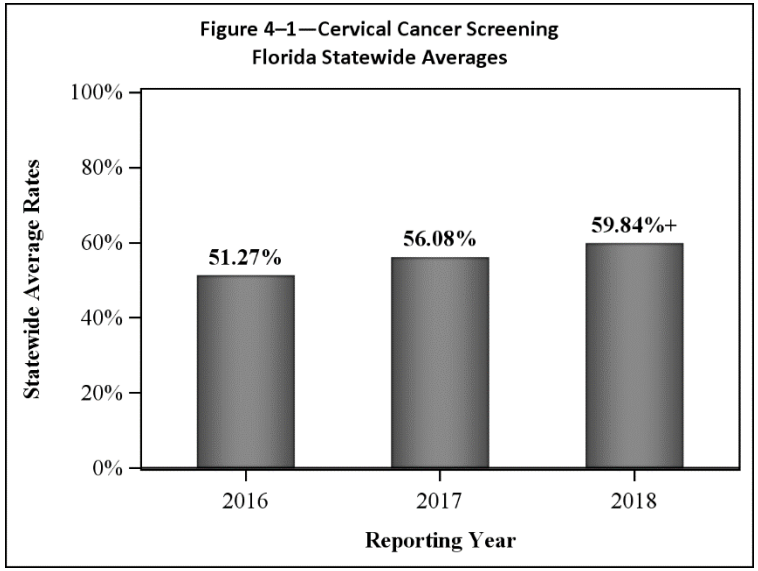
Table 11-1 shows that for the Women's Care domain, three of four statewide average rates (75 percent) that could be compared to national Medicaid benchmarks or the prior year's rates demonstrated significant increases from RY 2017 to RY 2018. Of note, the *Chlamydia Screening in Women—Total* statewide average rate was above the national Medicaid 75th percentile and increased significantly, indicating an area of strength for this domain.

Conversely, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* statewide average rate declined significantly from RY 2017 and RY 2018 and fell below the national Medicaid 50th percentile, demonstrating opportunities to improve care for pregnant women.

Measure-Specific Findings

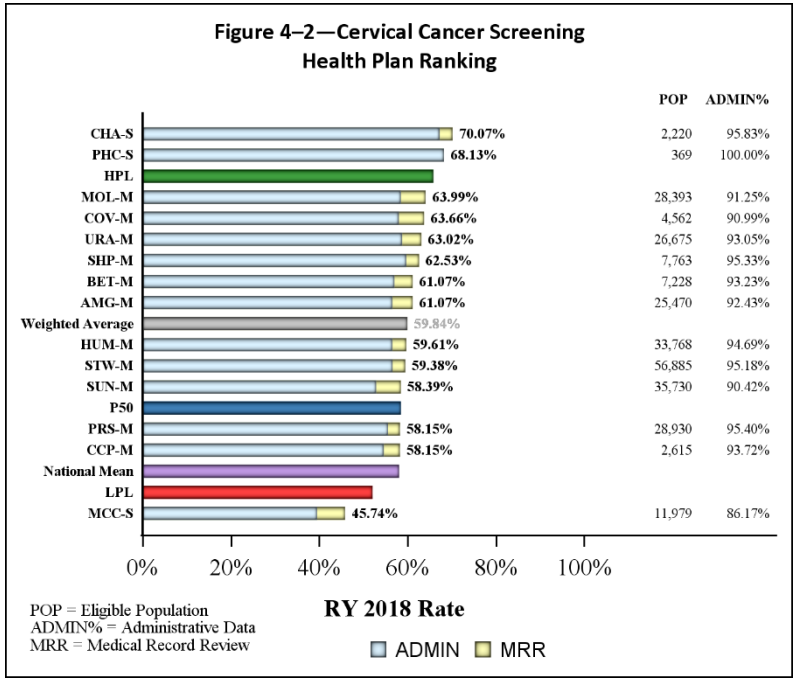
Cervical Cancer Screening

Cervical Cancer Screening assesses the percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria: Women ages 21 to 64 who had cervical cytology performed every three years or women ages 30 to 64 who had cervical cytology/HPV co-testing every five years.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

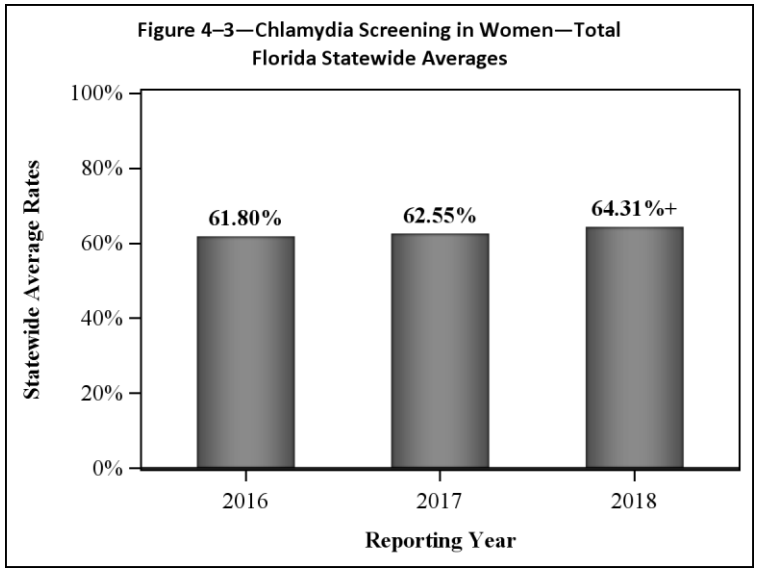
The RY 2018 statewide average rate significantly improved from RY 2017.



Ten MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with two MMA plans ranking above the HPL. One MMA plan fell below the LPL. MMA plan performance varied by nearly 25 percentage points.

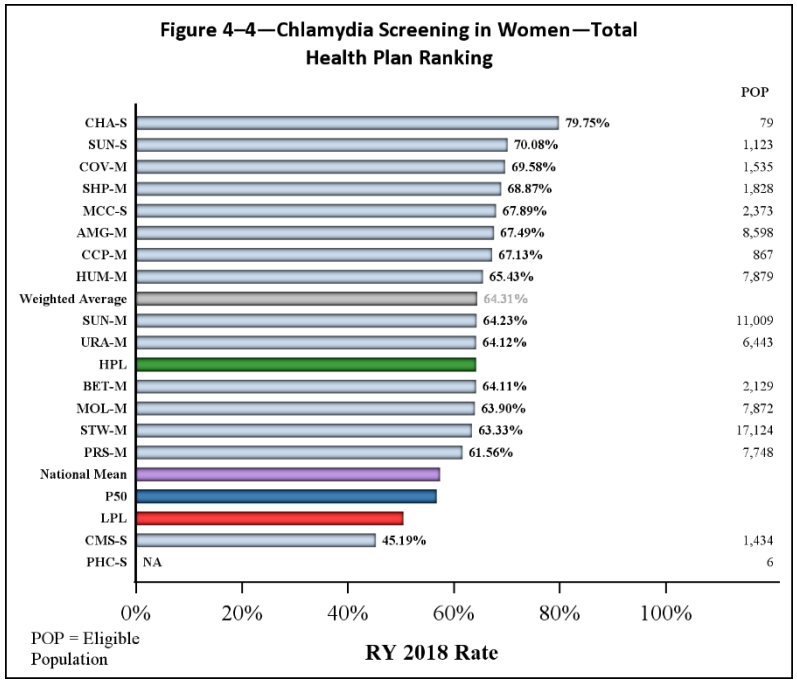
Chlamydia Screening in Women–Total

Chlamydia Screening in Women—Total represents the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

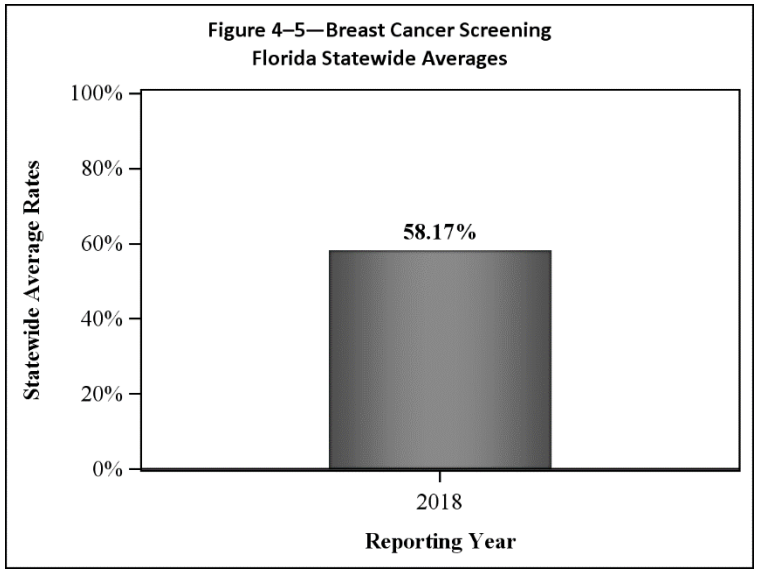


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

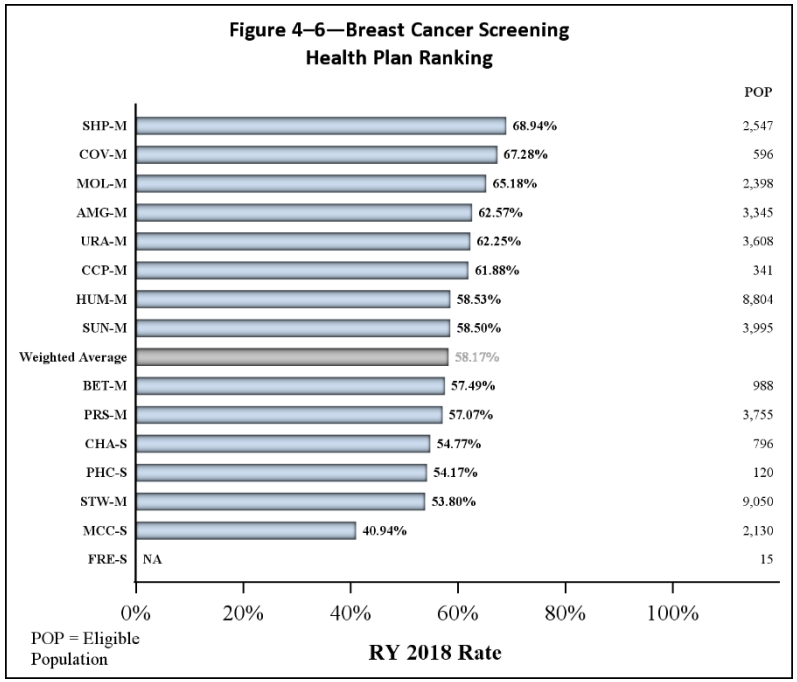
Fourteen MMA plans ranked above the national Medicaid 50th percentile, with 10 MMA plans and the statewide average ranking above the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by nearly 35 percentage points.

Breast Cancer Screening

Breast Cancer Screening assesses the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer on or after October 1 two years prior to the measurement year.



Due to changes to the RY 2018 technical specifications for this measure, NCQA does not recommend trending between 2018 and prior years; therefore, prior year statewide average rates are not displayed.



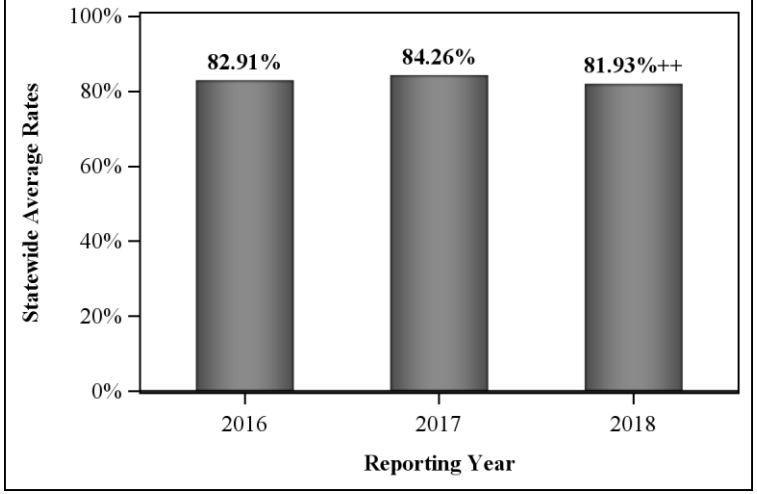
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Due to changes in the technical specifications in RY 2018 for this measure, a comparison to benchmarks is not appropriate. The rates in the chart above are presented for information only. MMA plan performance varied by nearly 30 percentage points.

Prenatal and Postpartum Care—Timeliness of Prenatal Care

Prenatal and Postpartum Care—Timeliness of Prenatal Care assesses the percentage of deliveries that received a prenatal care visit as an enrollee of the MMA plan in the first trimester or within 42 days of enrollment in the MMA plan.

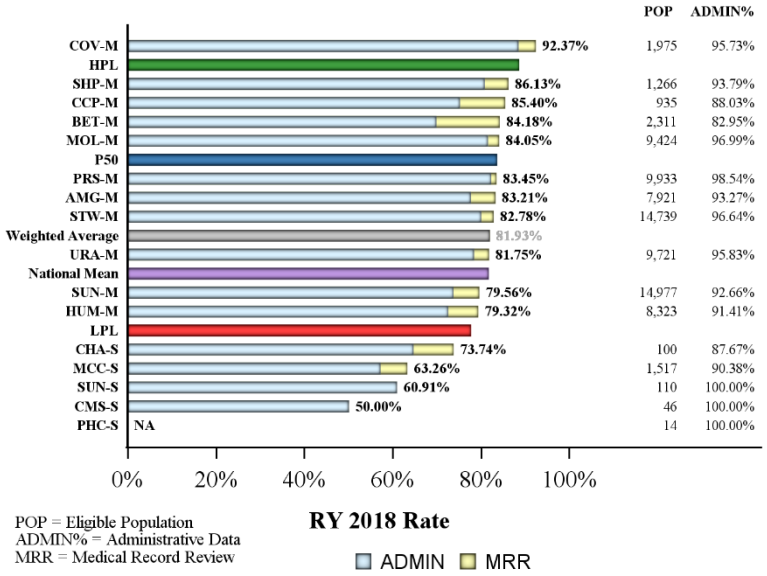
Figure 4–7—Prenatal and Postpartum Care—Timeliness of Prenatal Care
Florida Statewide Averages



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

Figure 4–8—Prenatal and Postpartum Care—Timeliness of Prenatal Care
Health Plan Ranking

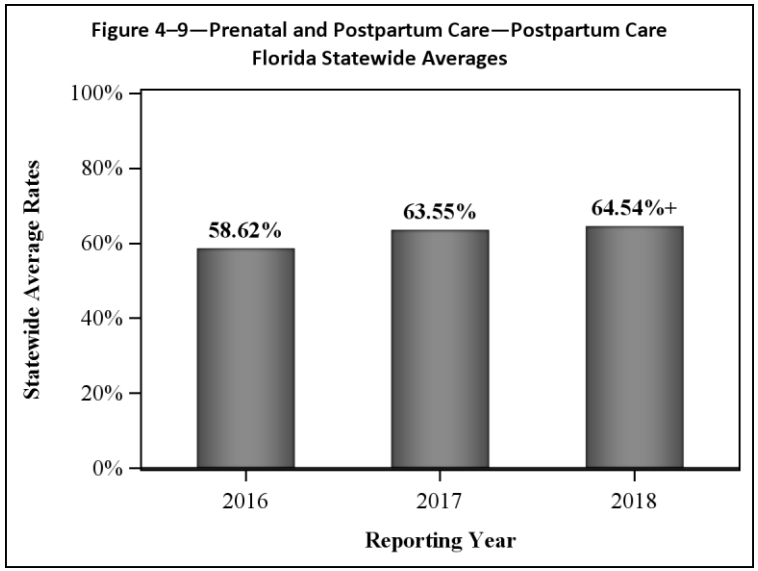


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Five MMA plans ranked above the national Medicaid 50th percentile, with one MMA plan ranking above the HPL. Four MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 40 percentage points.

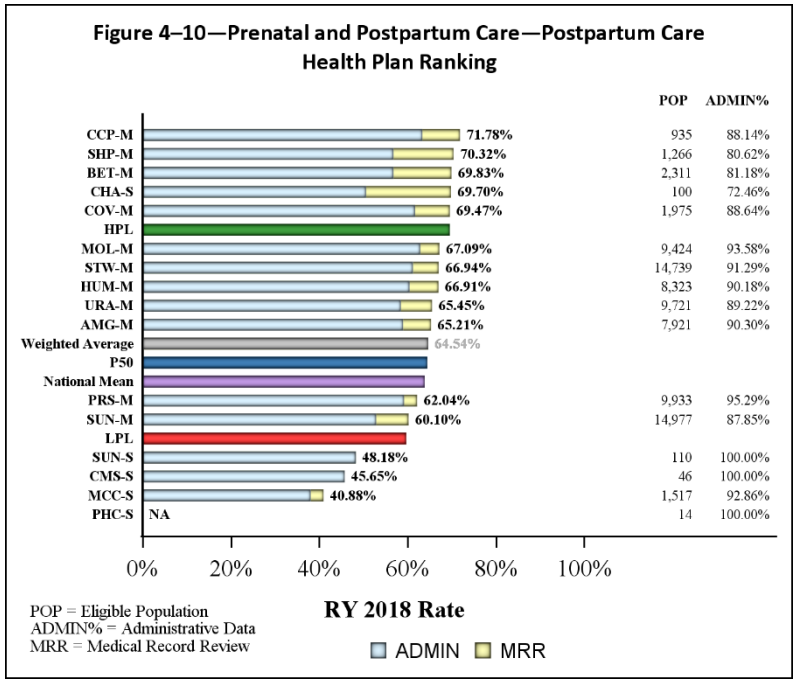
Prenatal and Postpartum Care—Postpartum Care

Prenatal and Postpartum Care—Postpartum Care represents the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Ten MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with five MMA plans ranking above the HPL. Three MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 30 percentage points.

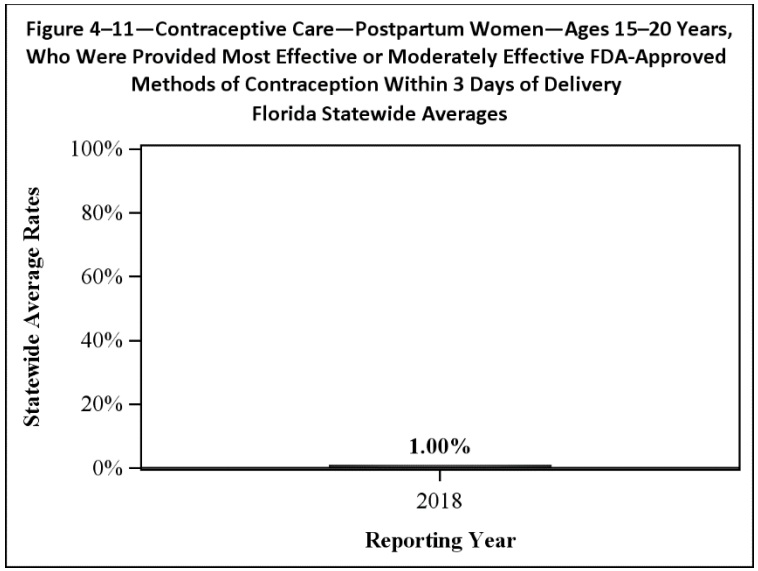
Contraceptive Care—Postpartum Women

Contraceptive Care—Postpartum Women assesses the percentage of women 15 to 44 who had a live birth that received contraceptive care. The MMA plans were required to report four rates for the *Ages 15 to 20 Years* and *Ages 21 to 44 Years* indicators:

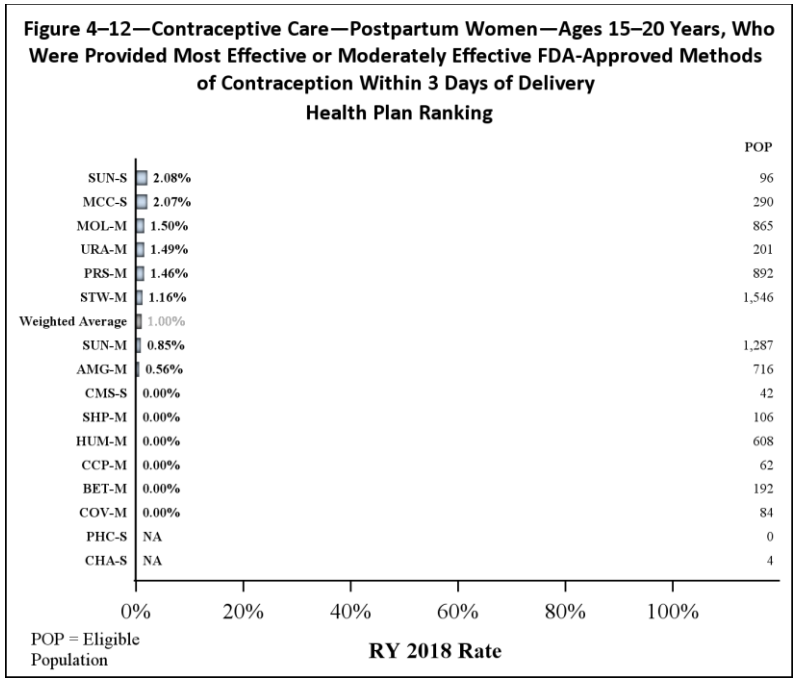
- Women who were provided most effective or moderately effective FDA-approved methods of contraception within 3 days (*Most or Moderately Effective—3 Days*).
- Women who were provided most effective or moderately effective FDA-approved methods of contraception within 60 days (*Most or Moderately Effective—60 Days*).
- Women who were provided a long-acting reversible method of contraception (LARC) within 3 days (*LARC—3 Days*).
- Women who were provided a LARC within 60 days (*LARC—60 Days*).

Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—Most or Moderately Effective—3 Days

Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—Most or Moderately Effective—3 Days measures the percentage of women ages 15 to 20 who received most effective or moderately effective FDA-approved methods of contraception within 3 days of delivery.



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.



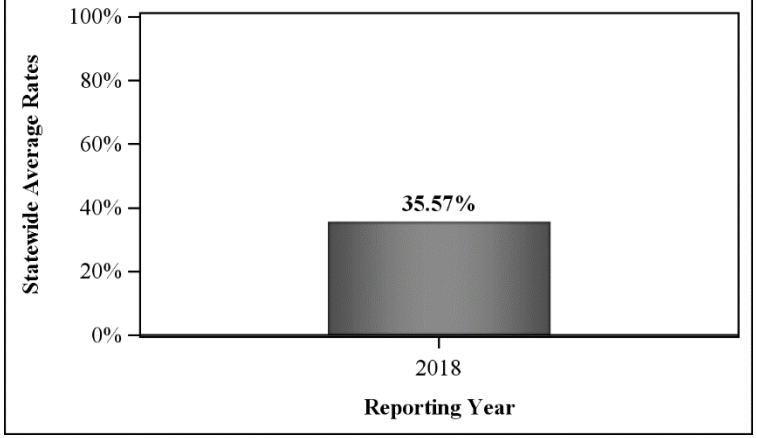
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by over 2 percentage points.

Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—Most or Moderately Effective—60 Days

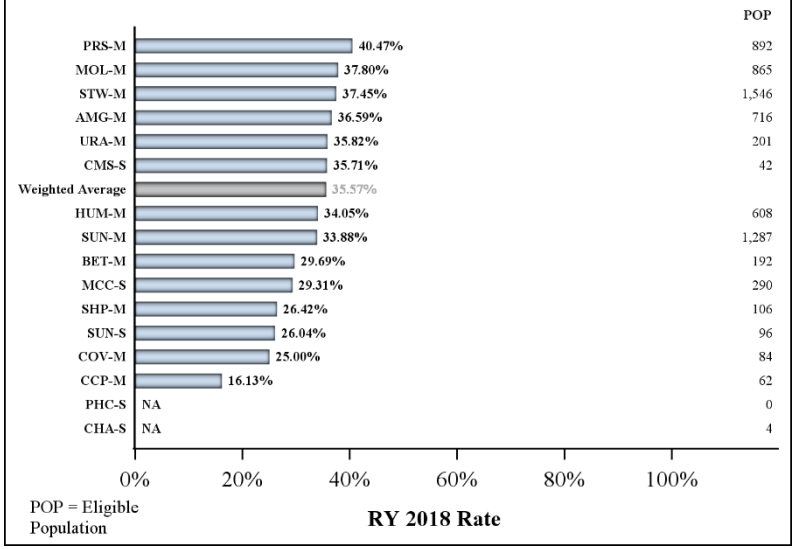
Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—Most or Moderately Effective—60 Days measures the percentage of women ages 15 to 20 who received most effective or moderately effective FDA-approved methods of contraception within 60 days of delivery.

Figure 4–13—Contraceptive Care—Postpartum Women—Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery
Florida Statewide Averages



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.

Figure 4–14—Contraceptive Care—Postpartum Women—Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery
Health Plan Ranking



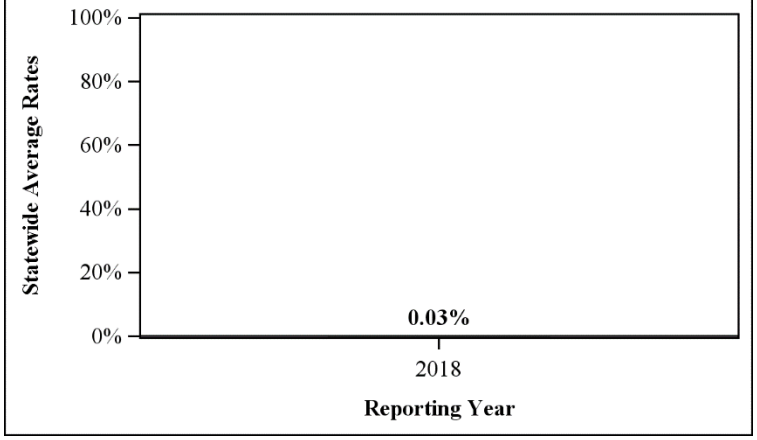
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by nearly 25 percentage points.

Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—LARC—3 Days

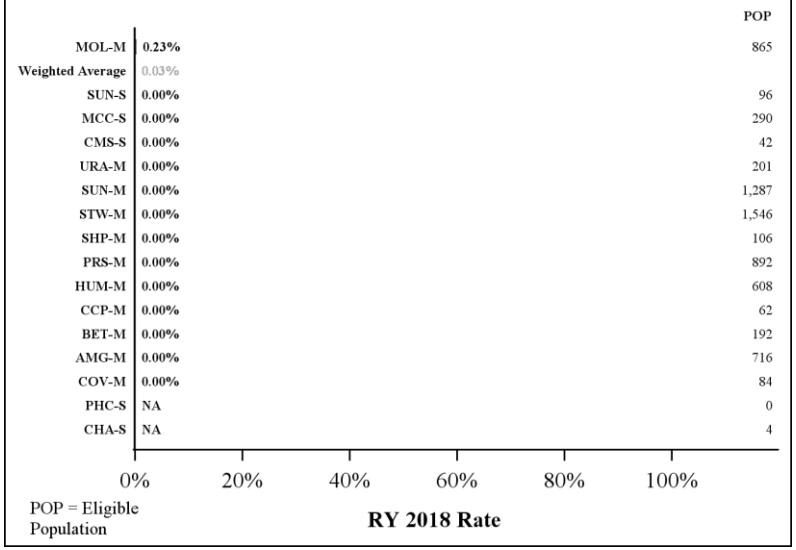
Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—LARC—3 Days—measures the percentage of women ages 15 to 20 who received a long-acting reversible method of contraception within 3 days of delivery.

Figure 4–15—Contraceptive Care—Postpartum Women—Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery
Florida Statewide Averages



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.

Figure 4–16—Contraceptive Care—Postpartum Women—Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery
Health Plan Ranking

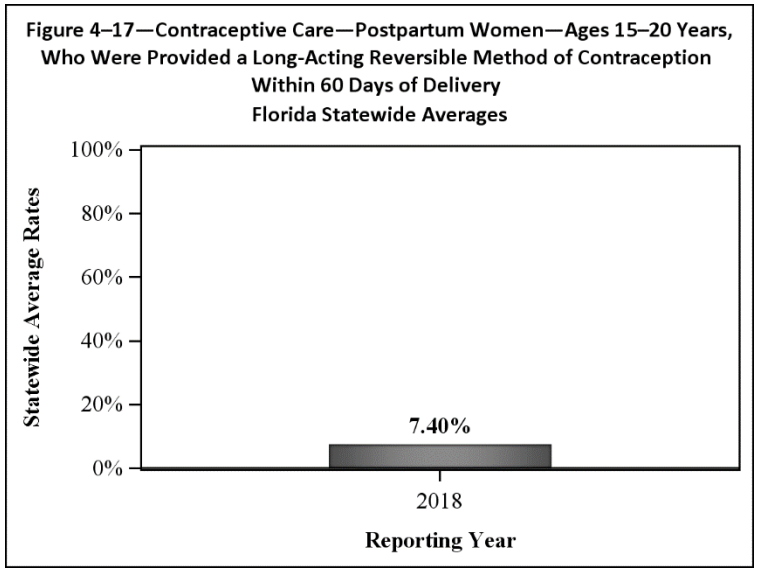


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

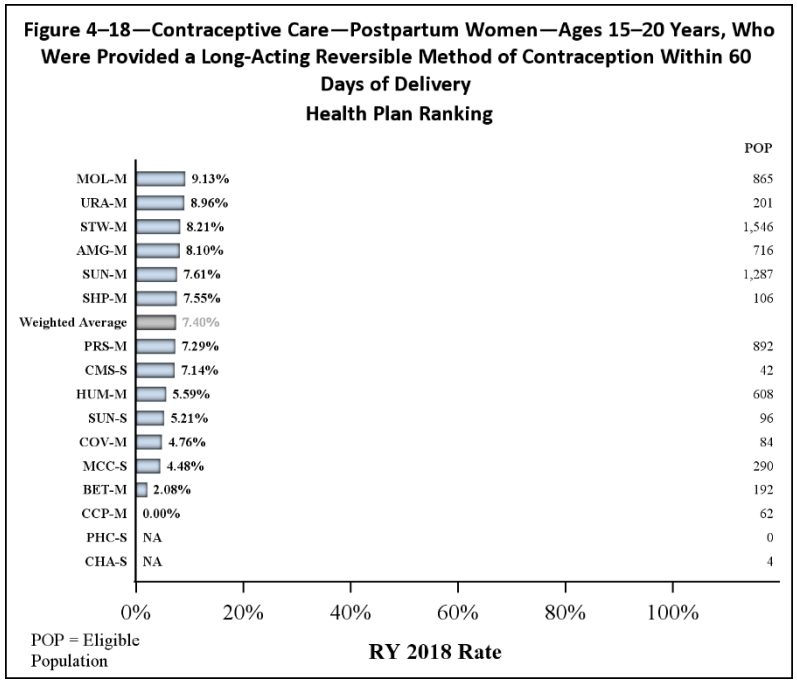
AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. All MMA plans with reportable rates (except one plan—MOL-M) had rates of 0 percent.

Contraceptive Care—Postpartum Women—Ages 15 to 20 Years—LARC—60 Days

Contraceptive Care—Postpartum Women—Ages 15 to 20 Years LARC—60 Days measures the percentage of women ages 15 to 20 who received a long-acting reversible method of contraception within 60 days of delivery.



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.



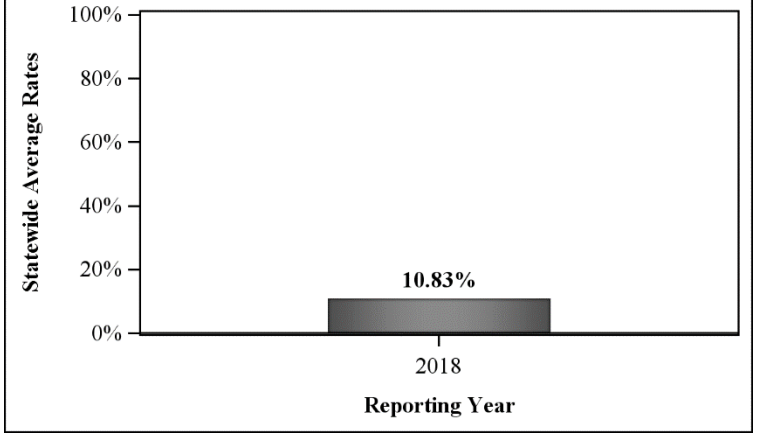
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by over 9 percentage points.

Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—Most or Moderately Effective—3 Days

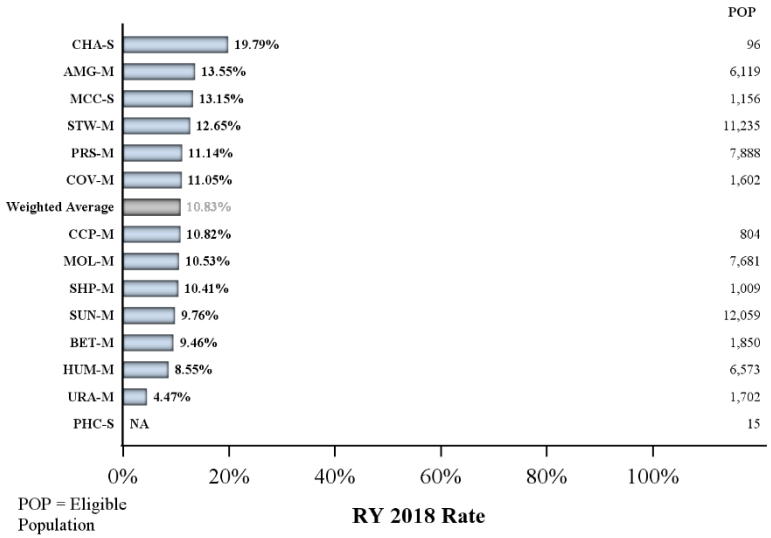
Contraceptive Care—Postpartum Women— Ages 21 to 44 Years—Most or Moderately Effective—3 Days measures the percentage of women ages 21 to 44 who received most effective or moderately effective FDA-approved methods of contraception within 3 days of delivery.

Figure 4–19—Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery
Florida Statewide Averages



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.

Figure 4–20—Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery
Health Plan Ranking



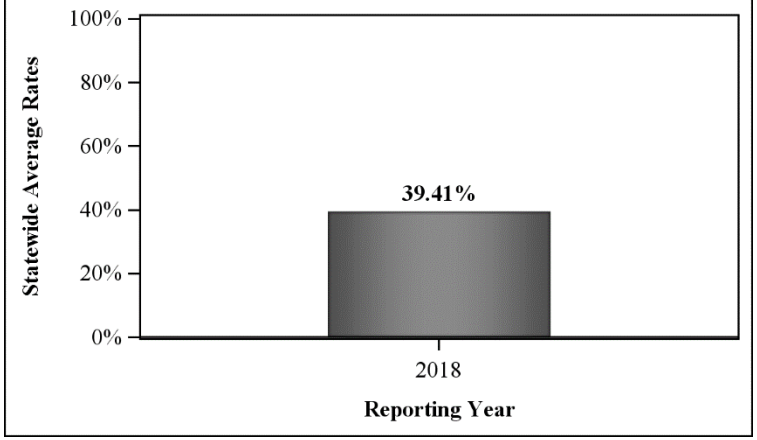
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by over 15 percentage points.

Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—Most or Moderately Effective—60 Days

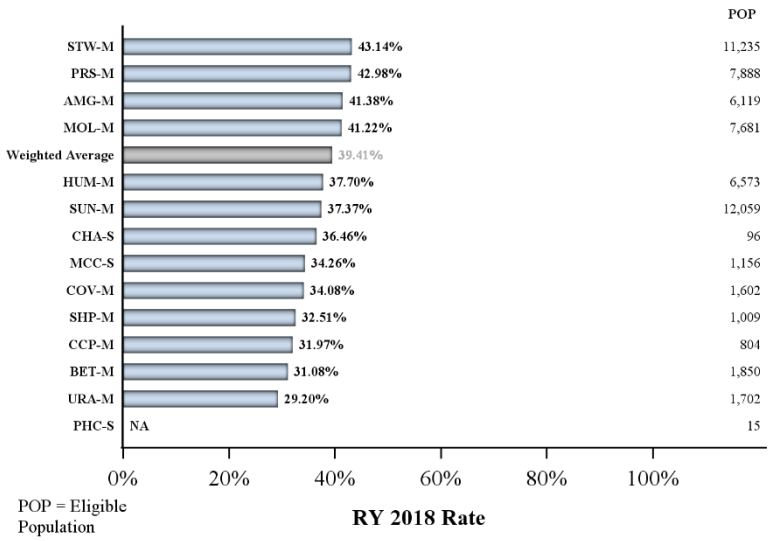
Contraceptive Care—Postpartum Women— Ages 21 to 44 Years—Most or Moderately Effective—60 Days—measures the percentage of women ages 21 to 44 who received most effective or moderately effective FDA-approved methods of contraception within 60 days of delivery.

Figure 4–21—Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery
Florida Statewide Averages



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.

Figure 4–22—Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery
Health Plan Ranking



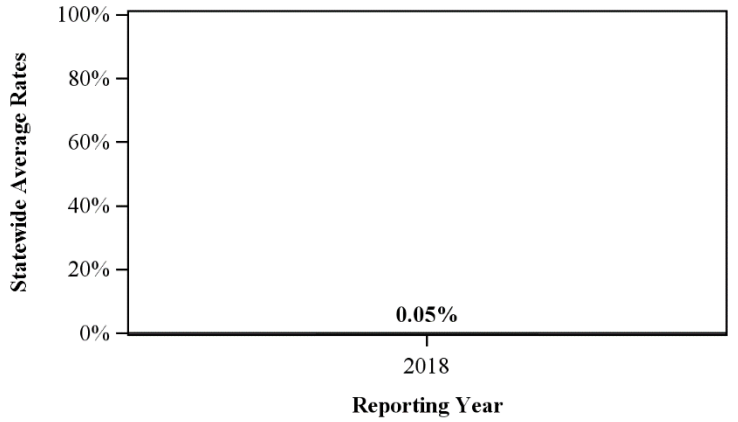
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by nearly 15 percentage points.

Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—LARC—3 Days

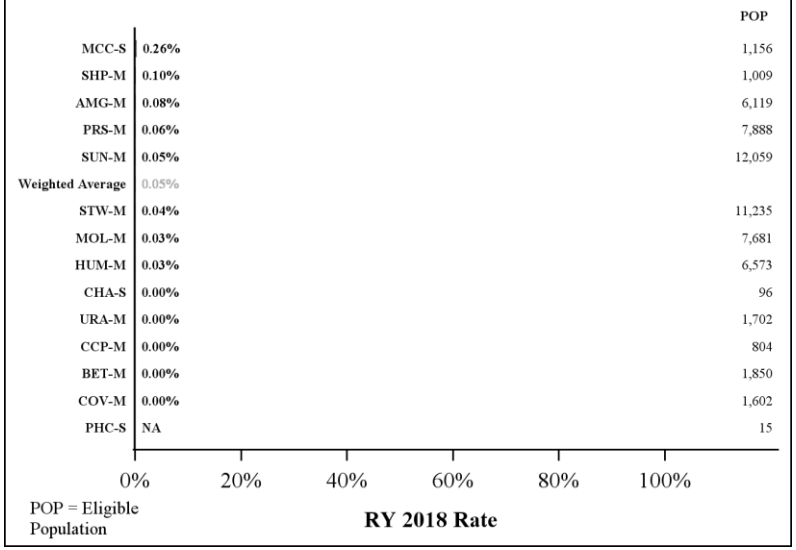
Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—LARC—3 Days measures the percentage of women ages 21 to 44 who received a long-acting reversible method of contraception within 3 days of delivery.

Figure 4–23—Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery
Florida Statewide Averages



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.

Figure 4–24—Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery
Health Plan Ranking



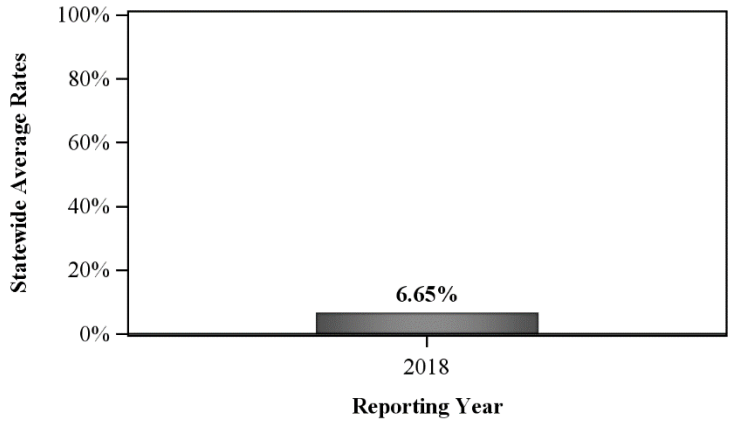
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by less than 1 percentage point.

Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—LARC—60 Days

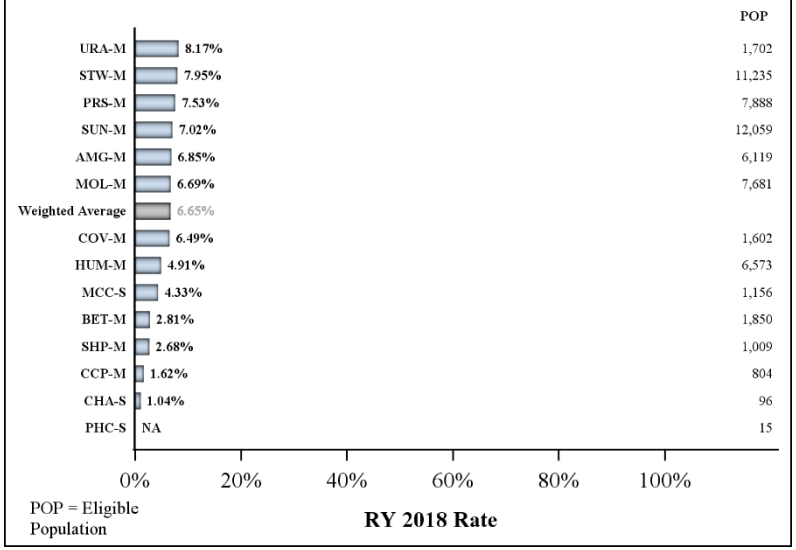
Contraceptive Care—Postpartum Women—Ages 21 to 44 Years—LARC—60 Days—measures the percentage of women ages 21 to 44 who received a long-acting reversible method of contraception within 60 days of delivery.

Figure 4–25—Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery
Florida Statewide Averages



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.

Figure 4–26—Contraceptive Care—Postpartum Women—Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery
Health Plan Ranking



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by over 7 percentage points.

12. Living With Illness

Introduction

The Living With Illness measure domain encompasses the following measures reported by the Standard and Specialty MMA plans:

- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed,* and *Medical Attention for Nephropathy*
- *Controlling High Blood Pressure*
- *Adult BMI Assessment*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*
- *Annual Monitoring for Patients on Persistent Medications—Total*
- *Plan All-Cause Readmissions—18–64 Years—Total* and *65+ Years—Total*
- *HIV Viral Load Suppression—18–64 Years* and *65+ Years*
- *Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total, Discussing Cessation Medications—Total,* and *Discussing Cessations Strategies—Total*
- *Care for Older Adults—Advance Care Planning—66+ Years, Medication Review—66+ Years, Functional Status Assessment—66+ Years,* and *Pain Assessment—66+ Years*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented in this section. For reference, additional analyses for each measure indicator are displayed in Appendix D.

Summary of Findings

Table 12-1 presents the statewide average performance for the measure indicators under the Living With Illness measure domain. The table lists the RY 2018 statewide average and performance levels, a comparison of the RY 2017 to the RY 2018 statewide average for each measure indicator with trend analysis results, and a summary of the MMA plans with rates demonstrating statistically significant changes from RY 2017 to RY 2018.

Table 12-1—RY 2018 Statewide Performance Levels and Trend Results for Living With Illness

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of MMA Plans With Statistically Significant Improvement in RY 2018	Number of MMA Plans With Statistically Significant Decline in RY 2018
Comprehensive Diabetes Care				
HbA1c Testing	85.69%	**+3.74⁺**	2	0
*HbA1c Poor Control (>9.0%)**	40.90%	**-4.51⁺**	2	0
HbA1c Control (<8.0%)	49.22%	**+5.13⁺**	4	0
Eye Exam (Retinal) Performed	55.26%	-0.61	4	2
Medical Attention for Nephropathy	92.88%	**+1.97⁺**	1	0
Controlling High Blood Pressure				
Controlling High Blood Pressure	55.03%	+0.18	3	2
Adult BMI Assessment				
Adult BMI Assessment	89.68%	**+2.47⁺**	4	0
Medication Management for People With Asthma				
Medication Compliance 50%—Total[3]	55.35%	**+1.35⁺**	6	3
Medication Compliance 75%—Total	28.98%	+0.16	4	2
Annual Monitoring for Patients on Persistent Medications[4]				
Total	92.92%	NC	NC	NC
Plan All-Cause Readmissions				
*18–64 Years—Total**	23.24%	**-0.77⁺**	4	3
*65+ Years—Total**	13.56%	+0.11	3	1
HIV Viral Load Suppression				
18–64 Years	10.80%	**-2.82⁺⁺**	1	4
65+ Years	4.10%	-2.43	1	0
Medical Assistance With Smoking and Tobacco Use Cessation[5]				
Advising Smokers and Tobacco Users to Quit—Total	82.23%	**+41.00⁺**	2	0
Discussing Cessation Medications—Total	56.73%	**+29.09⁺**	2	0
Discussing Cessation Strategies—Total	51.50%	**+25.91⁺**	2	0
Care for Older Adults[6]				
Advance Care Planning—66+ Years	75.41%	-9.78	0	0
Functional Status Assessment—66+ Years	86.89%	-3.85	0	0
Medication Review—66+ Years	88.52%	-5.92	0	0
Pain Assessment—66+ Years	90.16%	-6.14	0	0

[1] 2018 performance levels were based on comparisons of the RY 2018 statewide average measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks. 2018 performance levels represent the following percentile comparisons:

≤25th	*≥25th and ≤49th*	*≥50th and ≤74th*	*≥75th and ≤89th*	*≥90th*

[2] RY 2017 statewide average to RY 2018 statewide average comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

[3]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total measure indicator rate, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmark.

[4]Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between 2018 and prior years; therefore, comparisons to the prior year's rates and benchmarks are not performed for this measure.

[5] The rates for this measure were weighted by the number of survey respondents (i.e., denominator) rather than the eligible population.

[6] Freedom-S was the only MMA-S plan to report this measure; therefore, exercise caution when interpreting the rates for this measure.

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

** For this indicator, a lower rate indicates better performance.*

Green Shading[+] *Indicates that the RY 2018 statewide average demonstrated a statistically significant improvement from the RY 2017 statewide average.*

Red Shading[++] *Indicates that the RY 2018 statewide average demonstrated a statistically significant decline from the RY 2017 statewide average.*

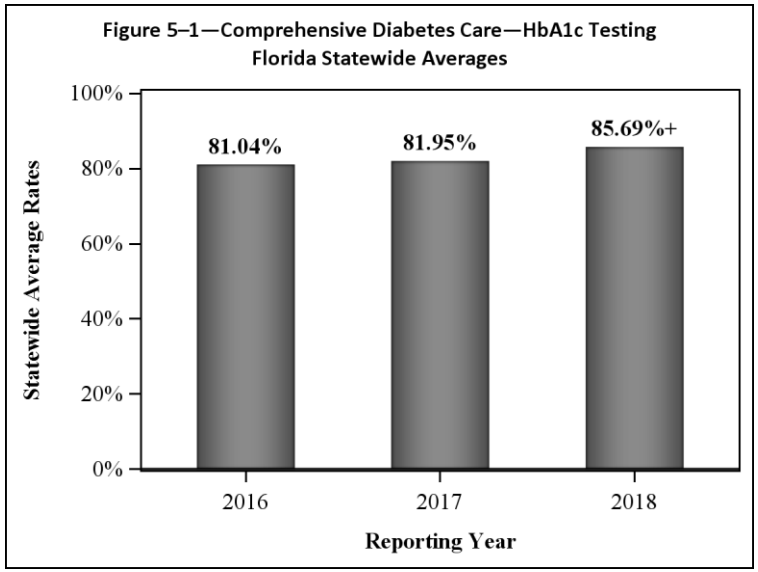
Table 12-1 shows that for the Living With Illness domain, 10 of 20 statewide average rates (50 percent) that could be compared to national Medicaid percentiles or the prior year's rates demonstrated significant increases from RY 2017 to RY 2018. Additionally, four of 12 statewide average rates (approximately 33 percent) exceeded the national Medicaid 75th percentile. Of note, the three *Medical Assistance With Smoking and Tobacco Use Cessation* statewide average rates exceeded the national Medicaid 75th percentile and had significant increases greater than 25 percentage points, demonstrating strengths for this domain.

Conversely, four of 12 statewide average rates (approximately 33 percent) fell below the national Medicaid 50th percentile; however, two of these statewide average rates demonstrated significant improvements from RY 2017 to RY 2018. Additionally, the statewide average rate for *HIV Viral Load Suppression—18–64 Years* demonstrated a significant decline from RY 2017 to RY 2018, further demonstrating opportunities to improve care for enrollees with chronic conditions.

Measure-Specific Findings

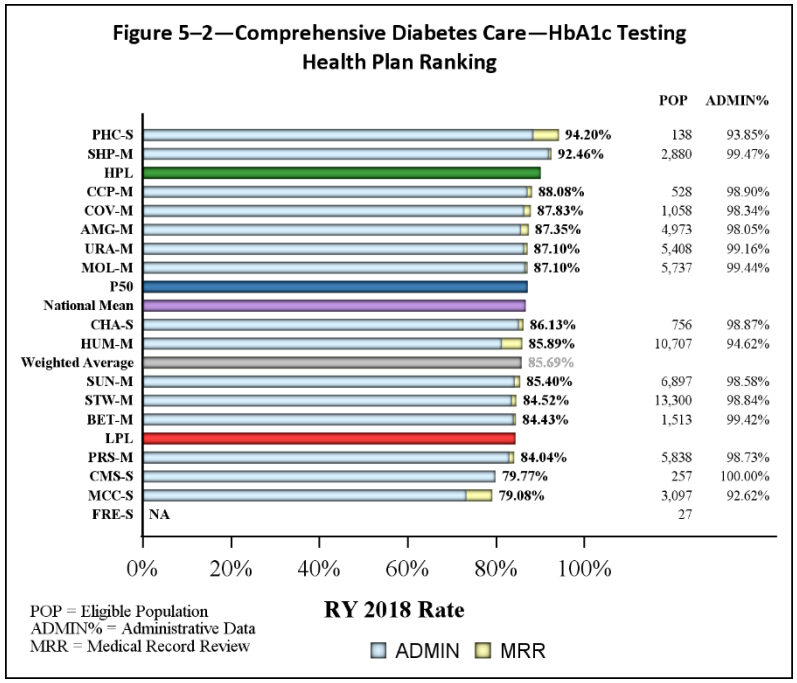
Comprehensive Diabetes Care—HbA1c Testing

Comprehensive Diabetes Care—HbA1c Testing assesses the percentage of enrollees 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c testing.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

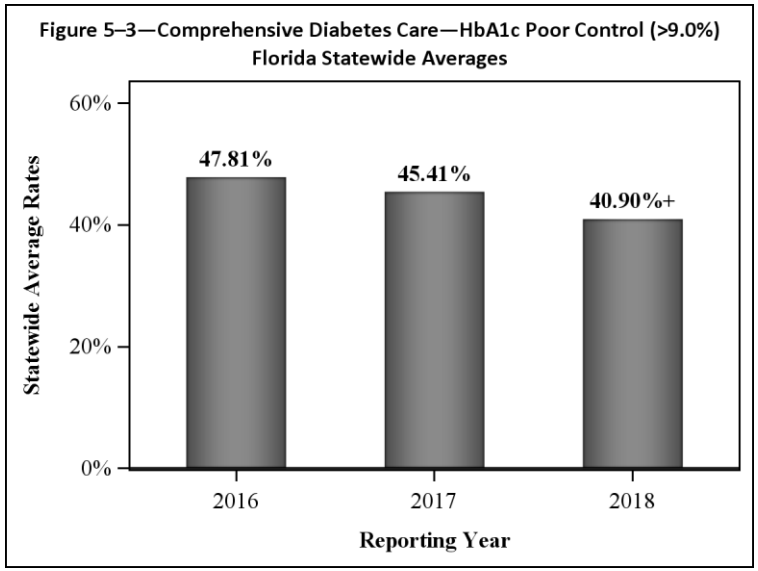


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Seven MMA plans ranked above the national Medicaid 50th percentile, with two MMA plans ranking above the HPL. Three MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 15 percentage points.

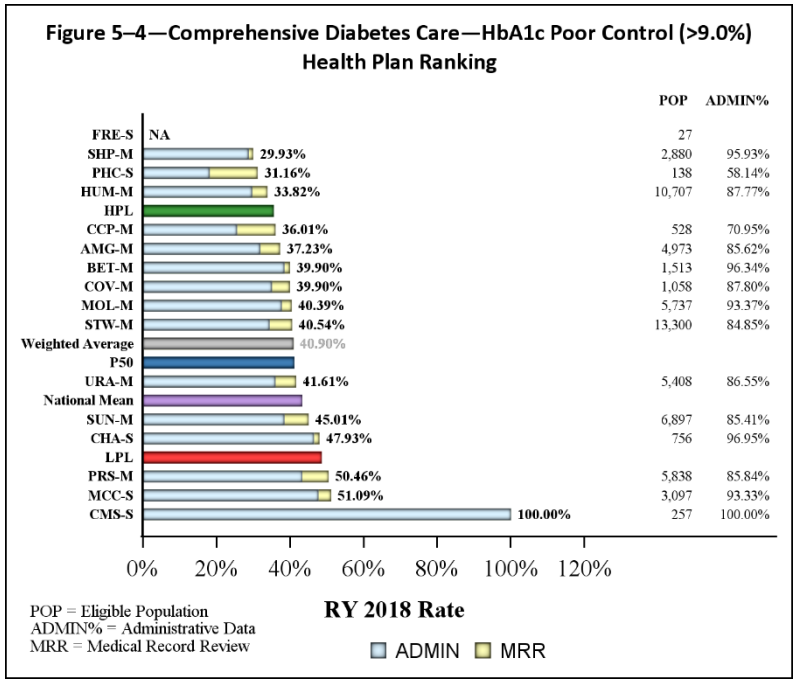
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)

Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) assesses the percentage of enrollees 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c poor control. For this measure, a lower rate indicates better performance.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

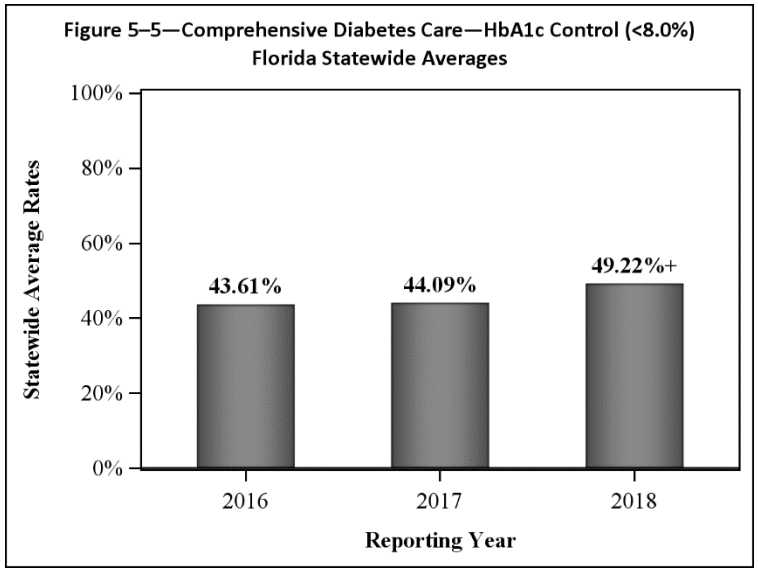


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Nine MMA plans with reportable rates and the statewide average ranked above the national Medicaid 50th percentile, with three MMA plans ranking above the HPL. Three MMA plans fell below the LPL. MMA plan performance varied by over 70 percentage points.

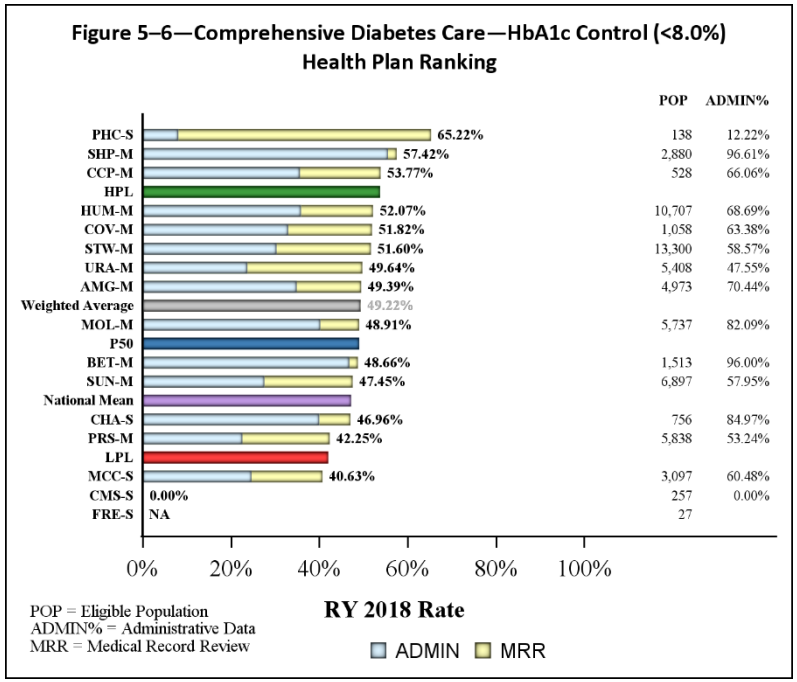
Comprehensive Diabetes Care—HbA1c Control (<8.0%)

Comprehensive Diabetes Care—HbA1c Control (<8.0%) assesses the percentage of enrollees 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

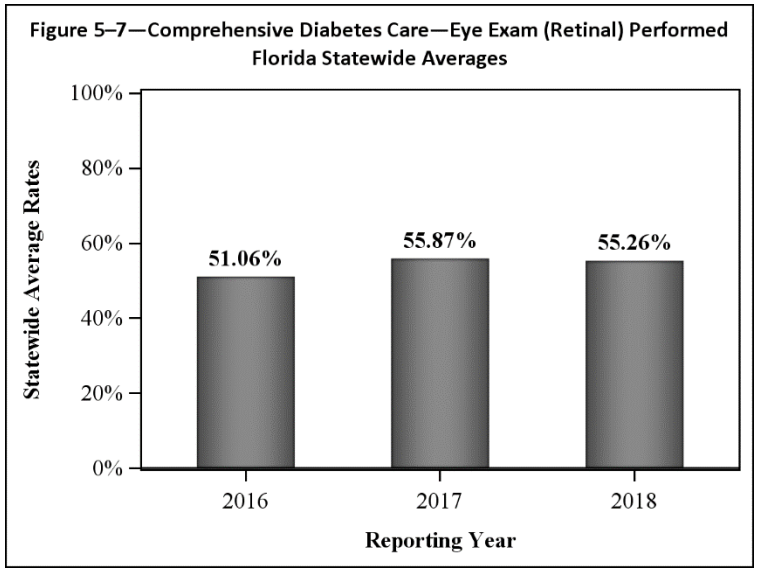


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

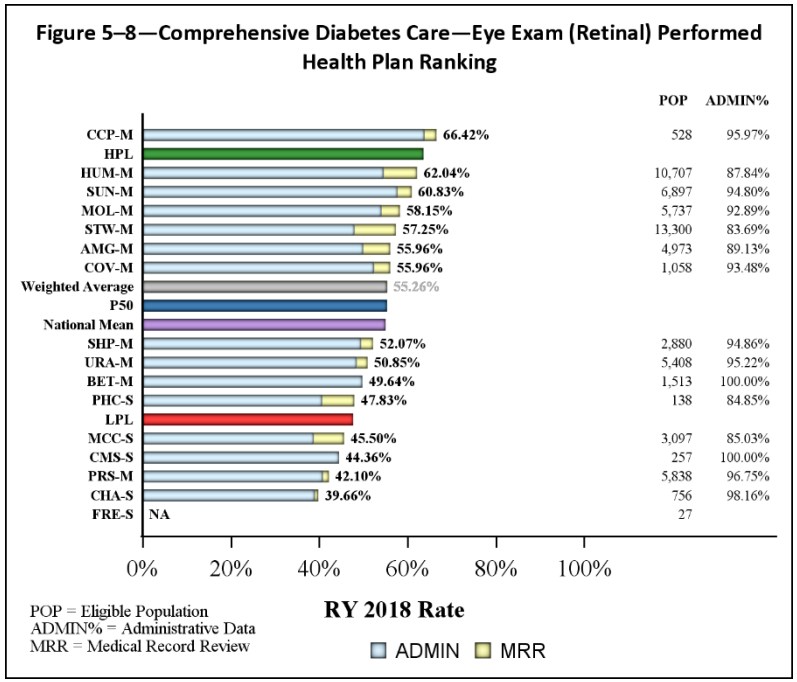
Nine MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with three MMA plans ranking above the HPL. Two MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 65 percentage points.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed assesses the percentage of enrollees 18 to 75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

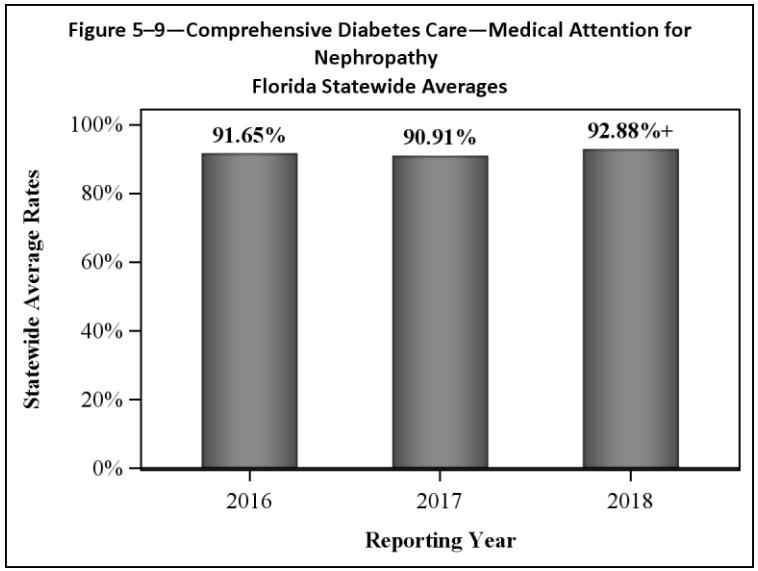


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Seven MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with one MMA plan ranking above the HPL. Four MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 25 percentage points.

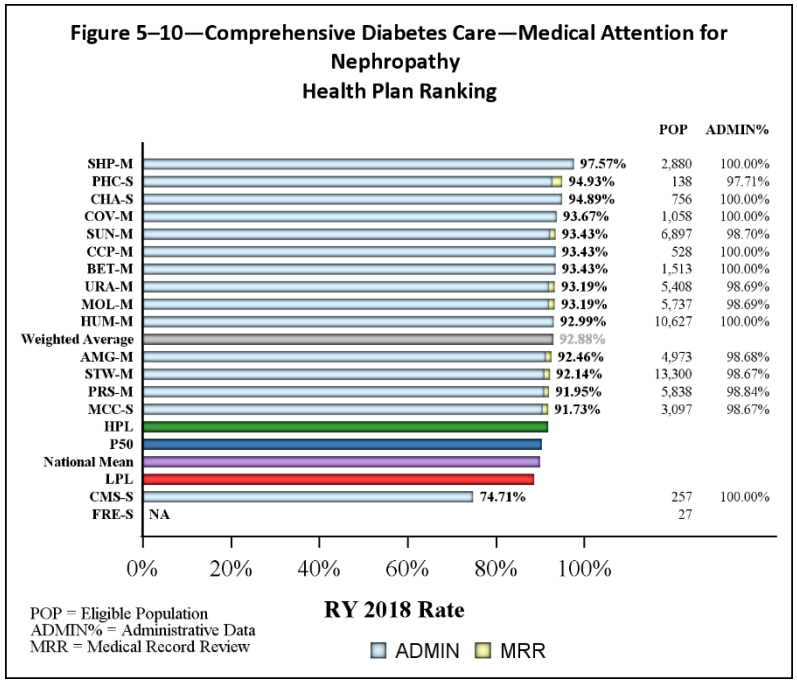
Comprehensive Diabetes Care—Medical Attention for Nephropathy

Comprehensive Diabetes Care—Medical Attention for Nephropathy assesses the percentage of enrollees 18 to 75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

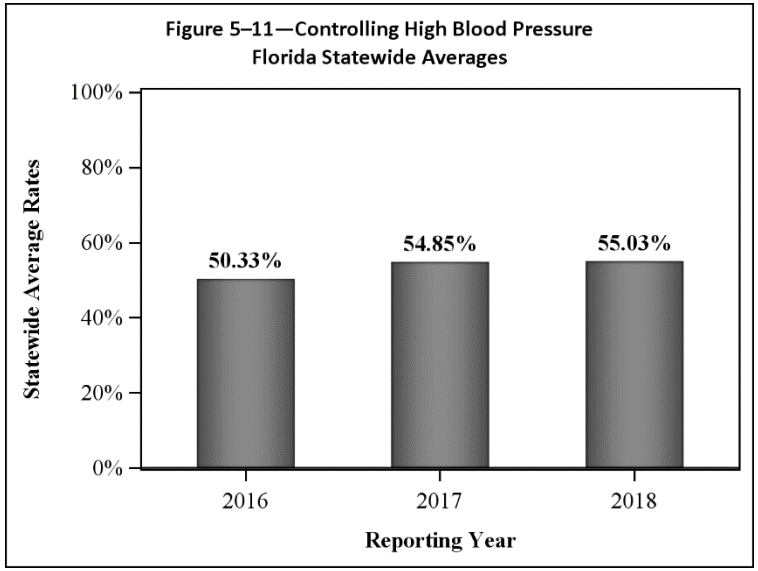


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

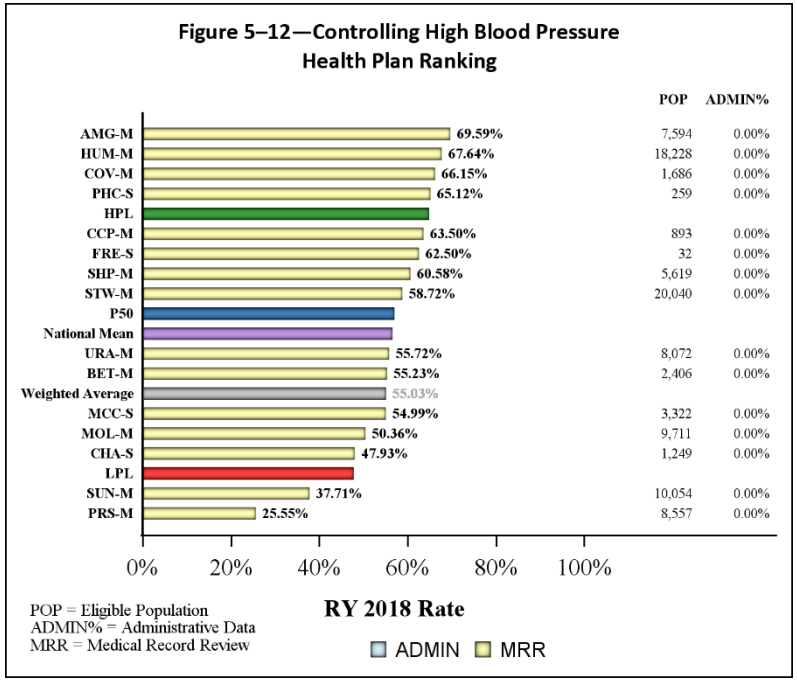
Fourteen MMA plans and the statewide average ranked above the national Medicaid 50th percentile and the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by over 20 percentage points.

Controlling High Blood Pressure

Controlling High Blood Pressure assesses the percentage of enrollees 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year based on the following criteria: Enrollees 18 to 59 years of age whose BP was <140/90 mm Hg; enrollees 60 to 85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg; and enrollees 60 to 85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.



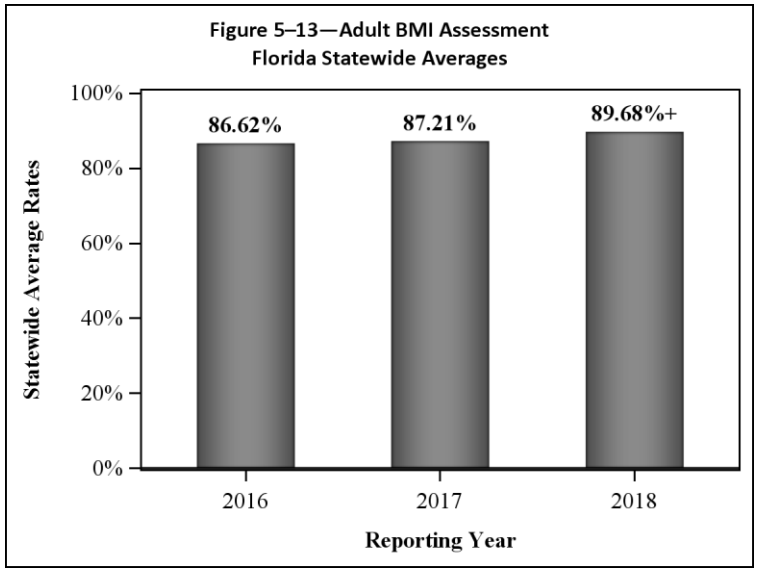
The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.



Eight MMA plans ranked above the national Medicaid 50th percentile, with four MMA plans ranking above the HPL. Two MMA plans fell below the LPL. MMA plan performance varied by nearly 45 percentage points.

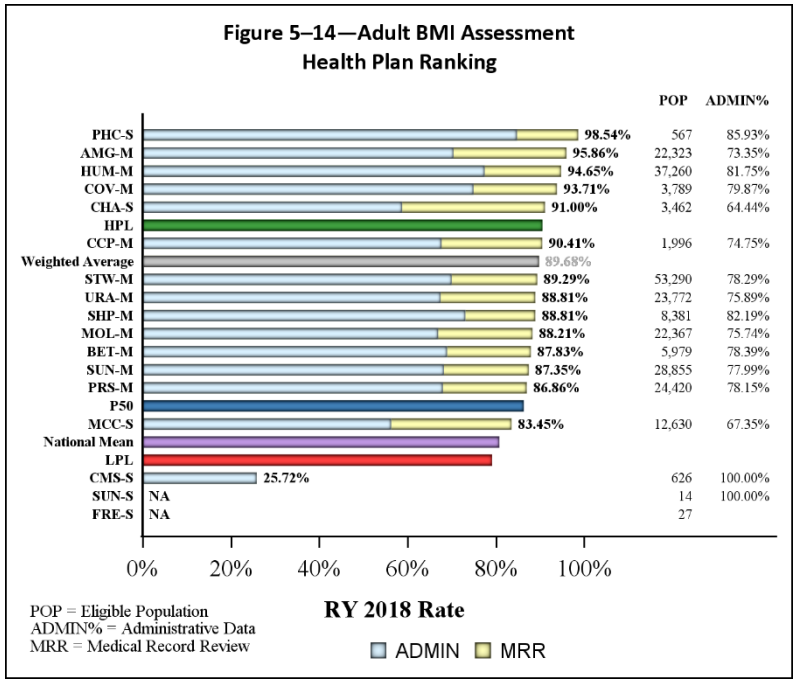
Adult BMI Assessment

Adult BMI Assessment assesses the percentage of enrollees 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



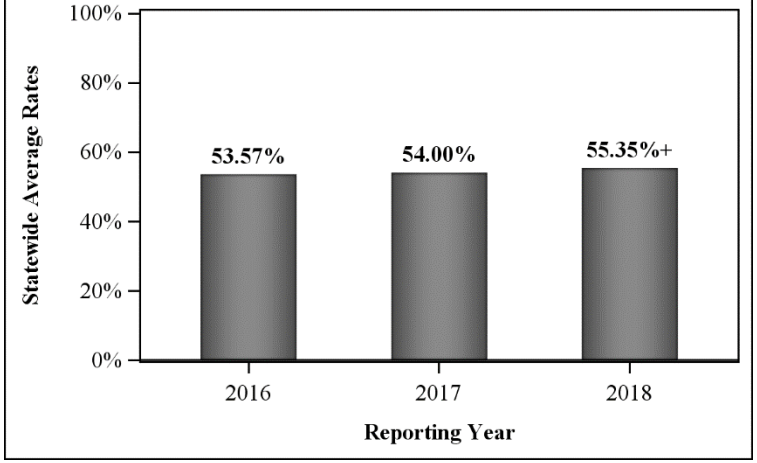
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Thirteen MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with five MMA plans ranking above the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by nearly 75 percentage points.

Medication Management for People With Asthma—Medication Compliance 50%—Total

Medication Management for People With Asthma—Medication Compliance 50%—Total assesses the percentage of enrollees 5 to 64 years of age who were identified as having persistent asthma and were dispensed appropriate medications that they continued to take for at least 50 percent of their treatment period.

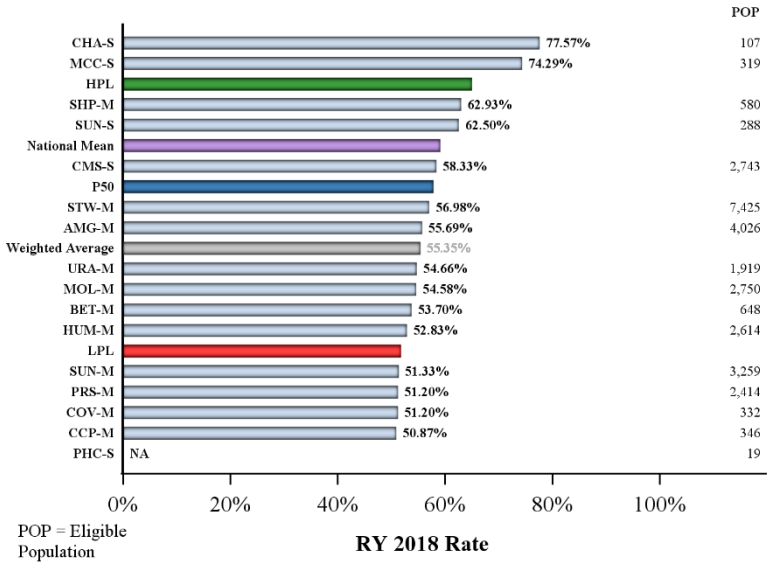
Figure 5–15—Medication Management for People With Asthma—Medication Compliance 50%—Total
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 5–16—Medication Management for People With Asthma—Medication Compliance 50%—Total
Health Plan Ranking



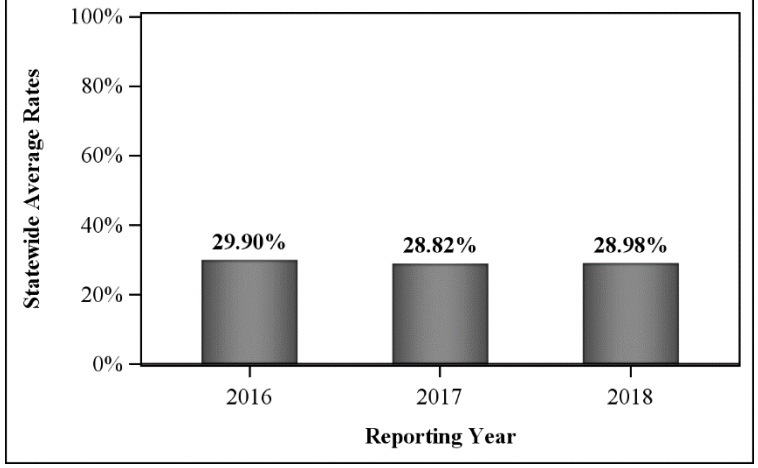
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
Quality Compass percentiles for this measure were not available; therefore, the rates for this measure indicator were compared to the NCQA Audit Means and Percentiles.

Five MMA plans ranked above the national Medicaid 50th percentile, with two MMA plans ranking above the HPL. Four MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 25 percentage points.

Medication Management for People With Asthma—Medication Compliance 75%—Total

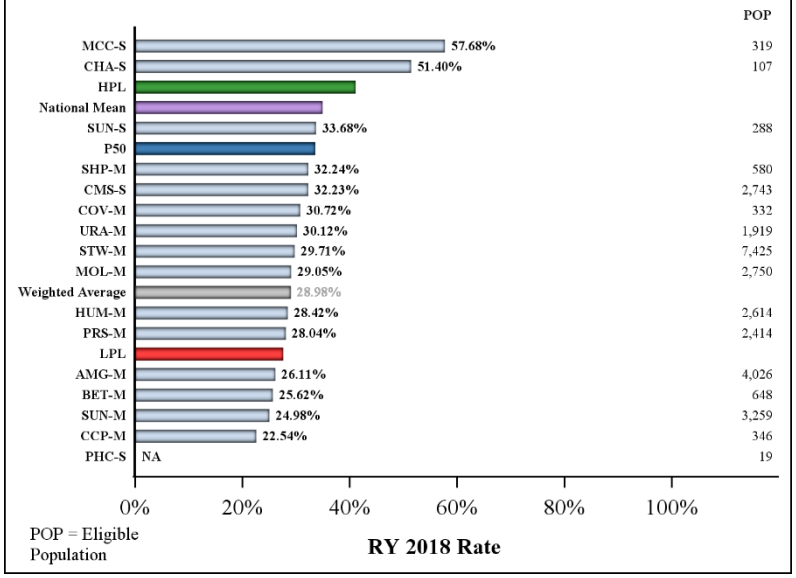
Medication Management for People With Asthma—Medication Compliance 75%—Total assesses the percentage of enrollees 5 to 64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they continued to take for at least 75 percent of their treatment period.

Figure 5–17—Medication Management for People With Asthma—Medication Compliance 75%—Total
Florida Statewide Averages



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

Figure 5–18—Medication Management for People With Asthma—Medication Compliance 75%—Total
Health Plan Ranking



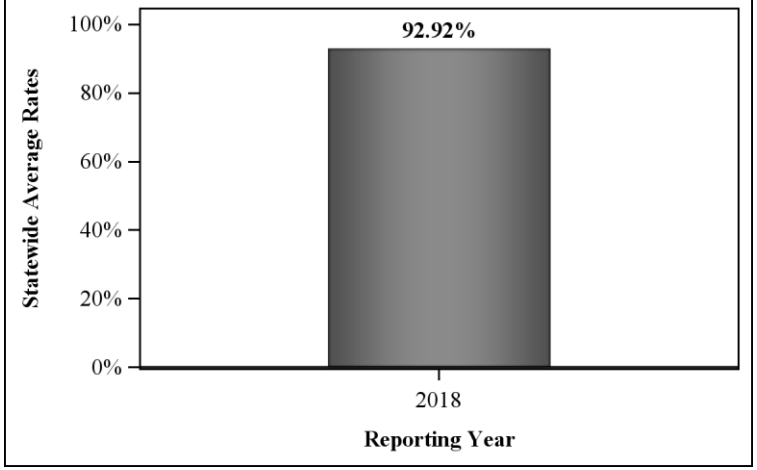
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Three MMA plans ranked above the national Medicaid 50th percentile, with two MMA plans ranking above the HPL. Four MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 35 percentage points.

Annual Monitoring for Patients on Persistent Medications—Total

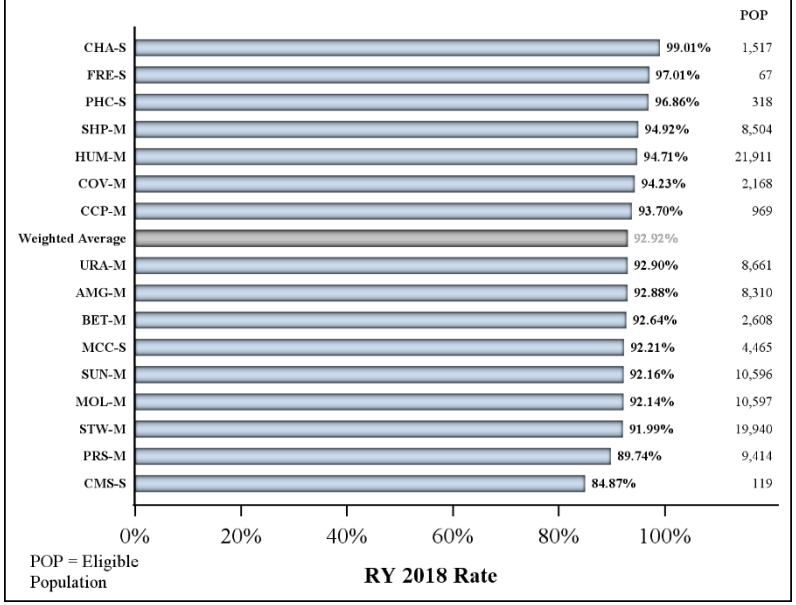
Annual Monitoring for Patients on Persistent Medications—Total assesses the percentage of patients 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs), or diuretics during the measurement year and had at least one serum therapeutic monitoring event for the agent in the measurement year.

Figure 5–19—Annual Monitoring for Patients on Persistent Medications—Total
Florida Statewide Averages



Due to changes to the RY 2018 technical specifications for this measure indicator, NCQA does not recommend trending between 2018 and prior years; therefore, prior year statewide average rates are not displayed.

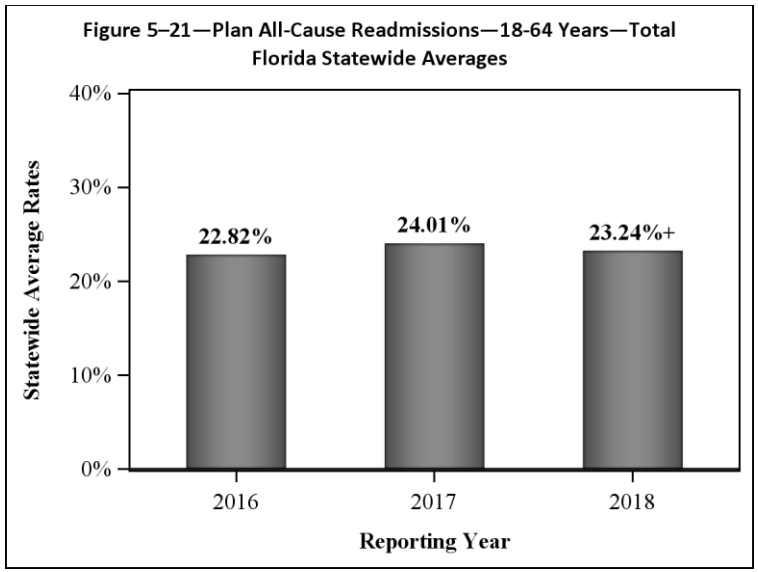
Figure 5–20—Annual Monitoring for Patients on Persistent Medications—Total
Health Plan Ranking



Due to changes in the technical specifications in RY 2018 for this measure, a comparison to benchmarks is not appropriate. The rates in the chart above are presented for information only. MMA plan performance varied by approximately 15 percentage points.

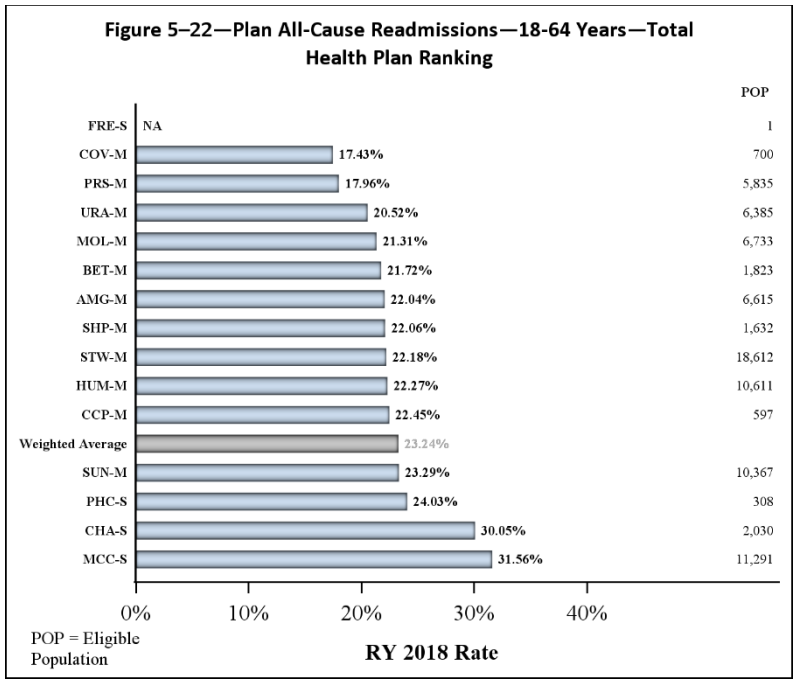
Plan All-Cause Readmissions—18–64 Years—Total

Plan All-Cause Readmissions—18–64 Years—Total measures the number of total acute inpatient stays during the measurement year for enrollees 18 to 64 years of age that were followed by an unplanned acute readmission for any diagnosis within 30 days. A lower rate indicates better performance for this measure.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

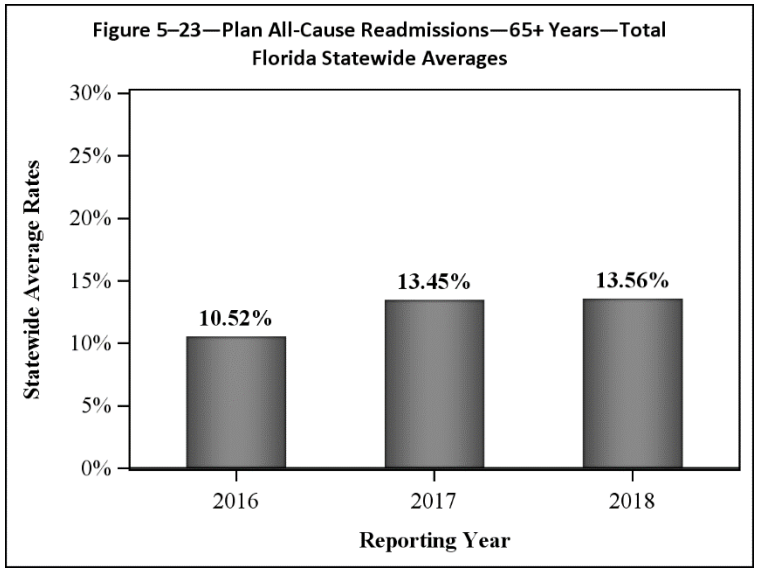


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

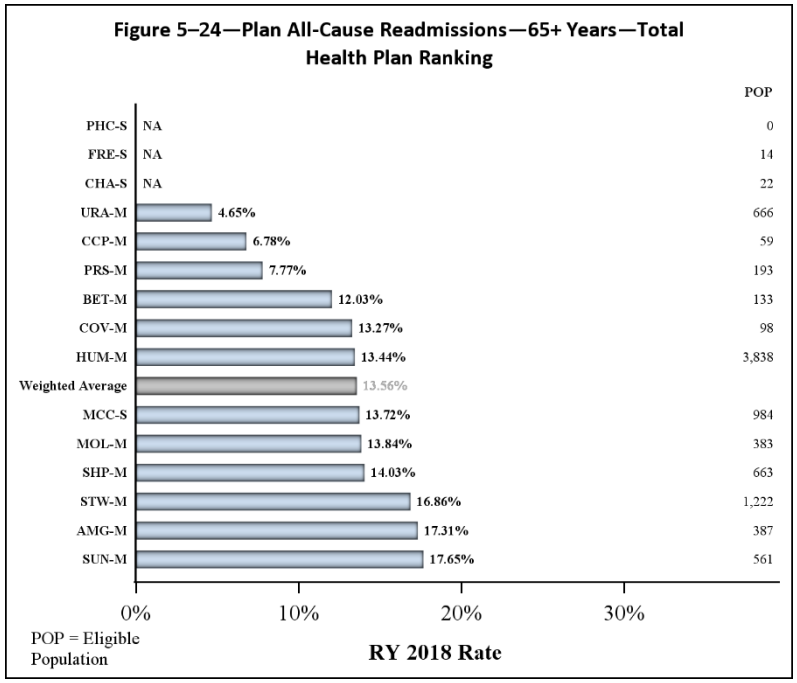
AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by nearly 15 percentage points.

Plan All-Cause Readmissions—65+ Years—Total

Plan All-Cause Readmissions—65+ Years—Total measures the number of total acute inpatient stays during the measurement year for enrollees 65 years of age and older that were followed by an unplanned acute readmission for any diagnosis within 30 days. A lower rate indicates better performance for this measure.



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

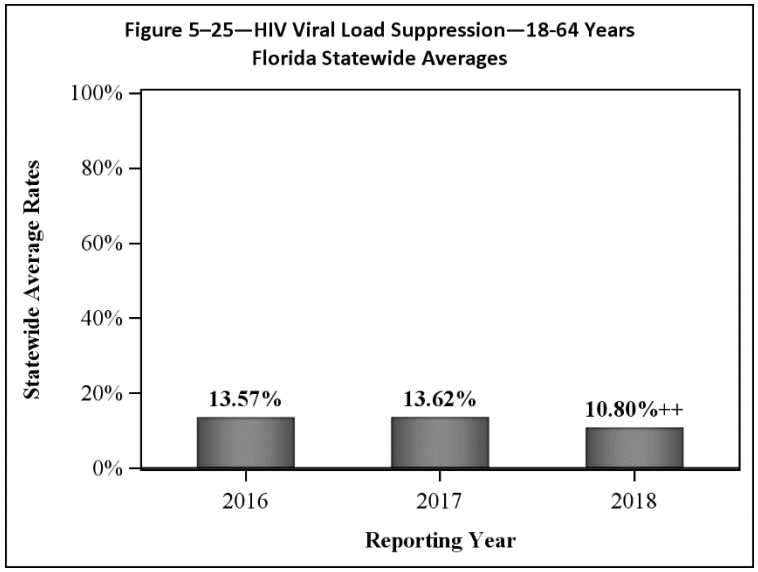


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by nearly 15 percentage points.

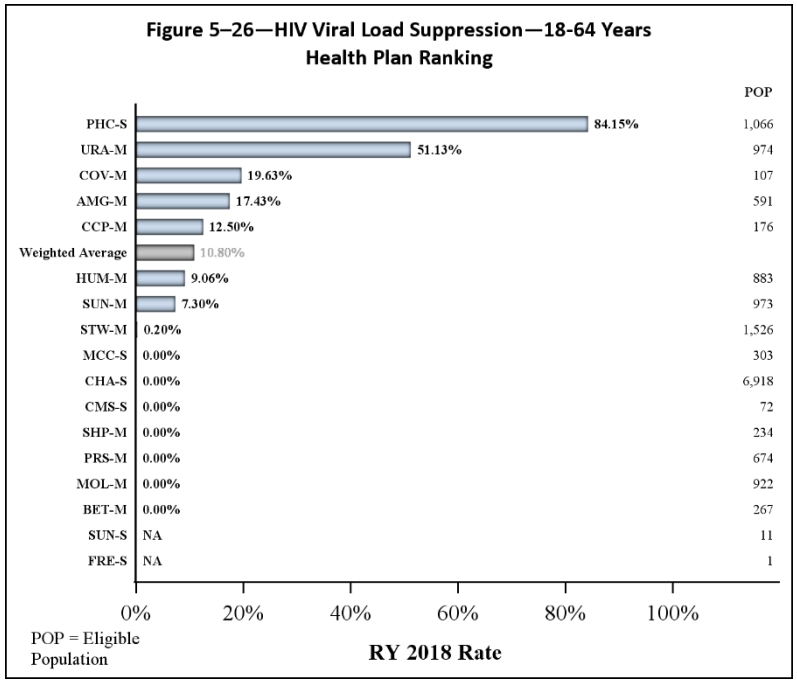
HIV Viral Load Suppression—18–64 Years

HIV Viral Load Suppression—18–64 Years assesses the percentage of enrollees ages 18 to 64 years with a diagnosis of HIV who had an HIV viral load less than 200 copies/mL at their last HIV viral load test during the measurement year. Due to issues associated with the plans obtaining complete HIV/AIDS lab data for this measure, low rates may be associated with a lack of complete data rather than cases of non-suppression of HIV viral load. Therefore, caution should be exercised when interpreting results.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

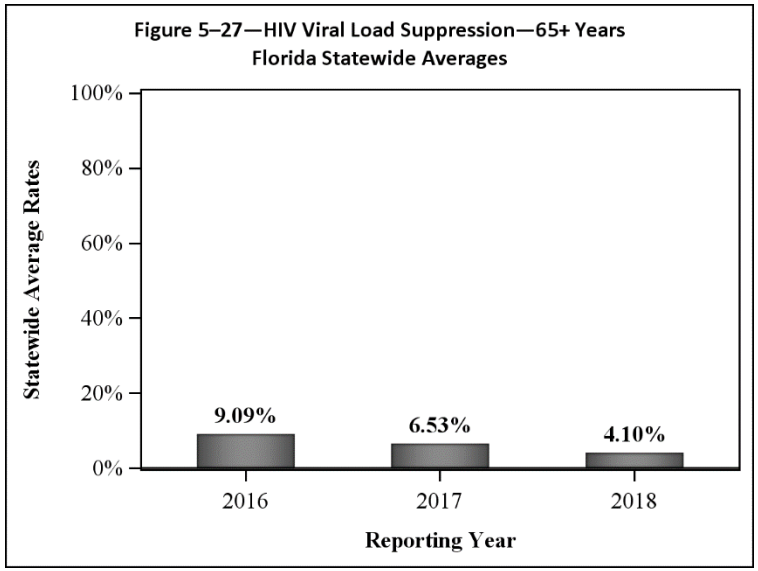


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

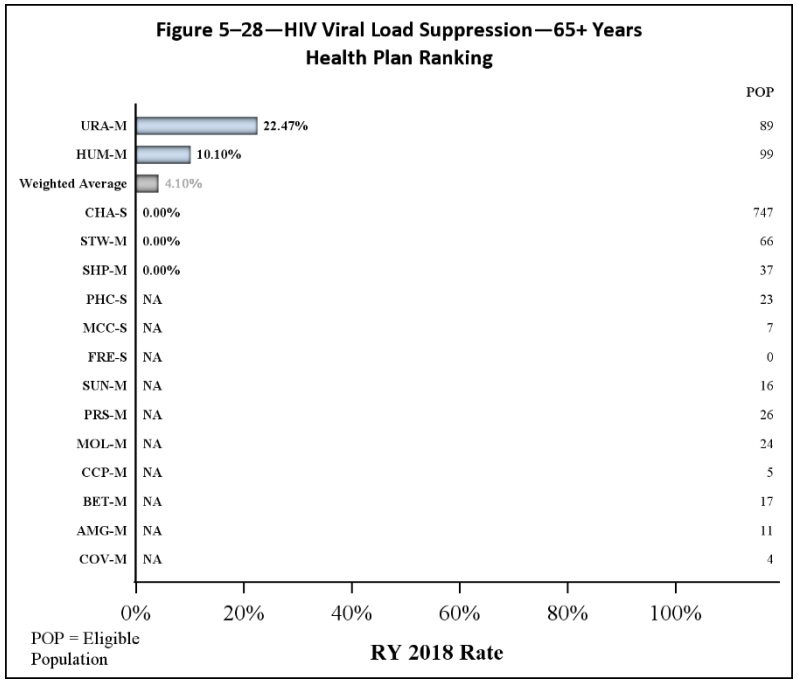
AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by nearly 85 percentage points.

HIV Viral Load Suppression—65+ Years

HIV Viral Load Suppression—65+ Years assesses the percentage of enrollees 65 years of age and older with a diagnosis of HIV who had an HIV viral load less than 200 copies/mL at their last HIV viral load test during the measurement year. Due to issues associated with the plans obtaining complete HIV/AIDS lab data for this measure, low rates may be associated with a lack of complete data rather than cases of non-suppression of HIV viral load. Therefore, caution should be exercised when interpreting results.



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.



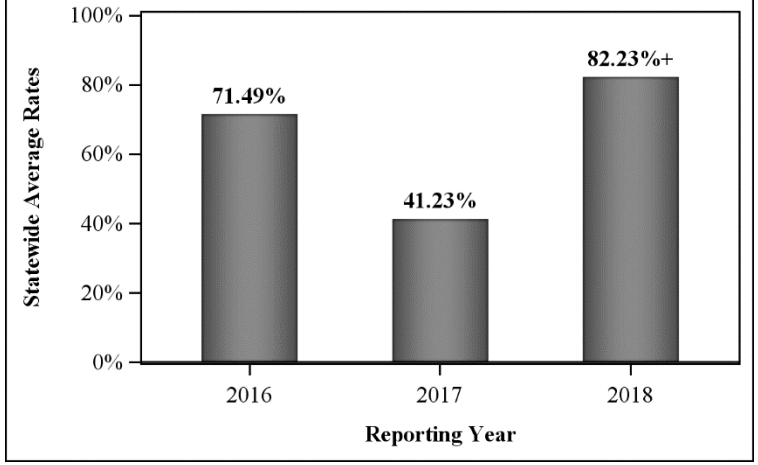
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by over 20 percentage points.

Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total

Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total assesses the percentage of enrollees 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year. The rates for this measure were weighted by the number of survey respondents (i.e., denominator) rather than the eligible population; therefore, exercise caution when comparing plan performance.

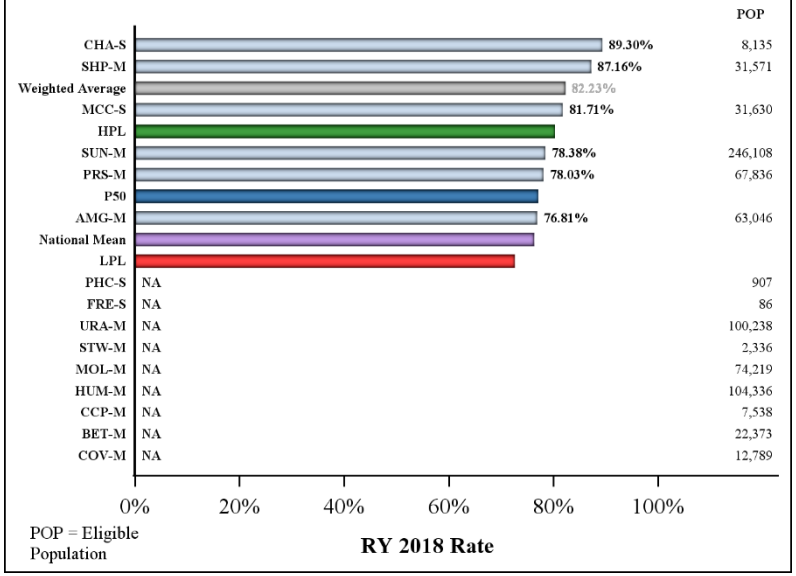
Figure 5–29—Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 5–30—Medical Assistance With Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total
Health Plan Ranking



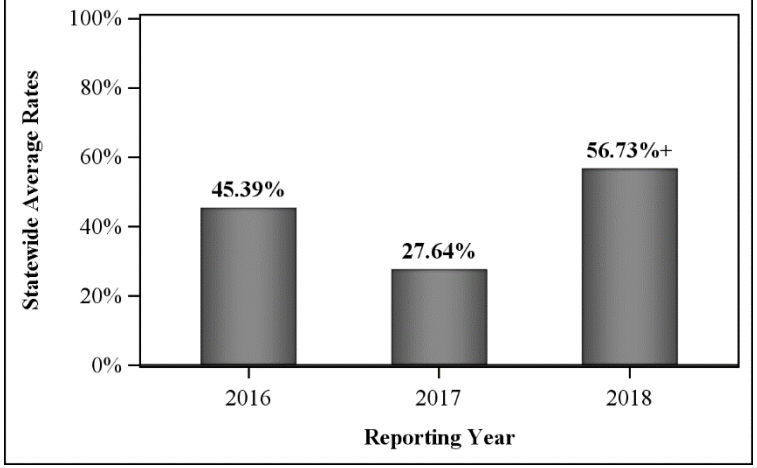
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<100) to report a valid rate.

Five MMA plans ranked above the national Medicaid 50th percentile, with three MMA plans and the statewide average ranking above the HPL. No MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 10 percentage points.

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total assesses the percentage of enrollees 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. The rates for this measure were weighted by the number of survey respondents (i.e., denominator) rather than the eligible population; therefore, exercise caution when comparing plan performance.

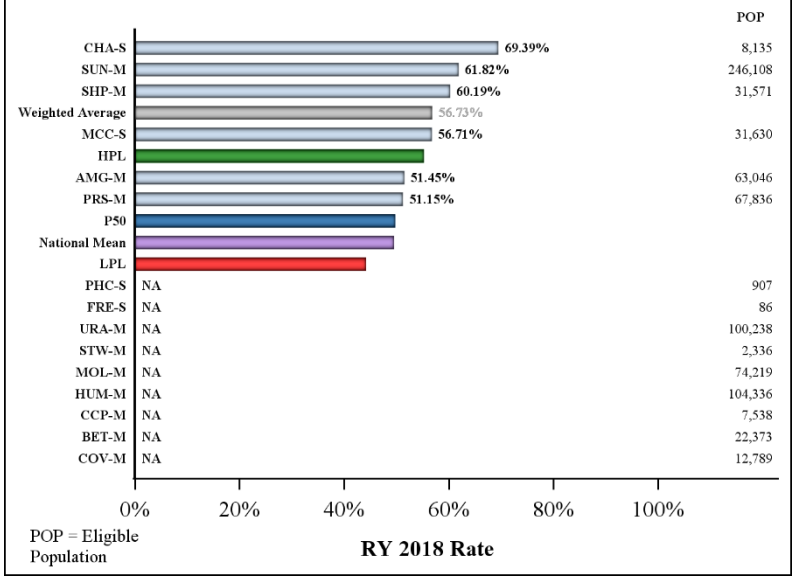
Figure 5–31—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 5–32—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total
Health Plan Ranking



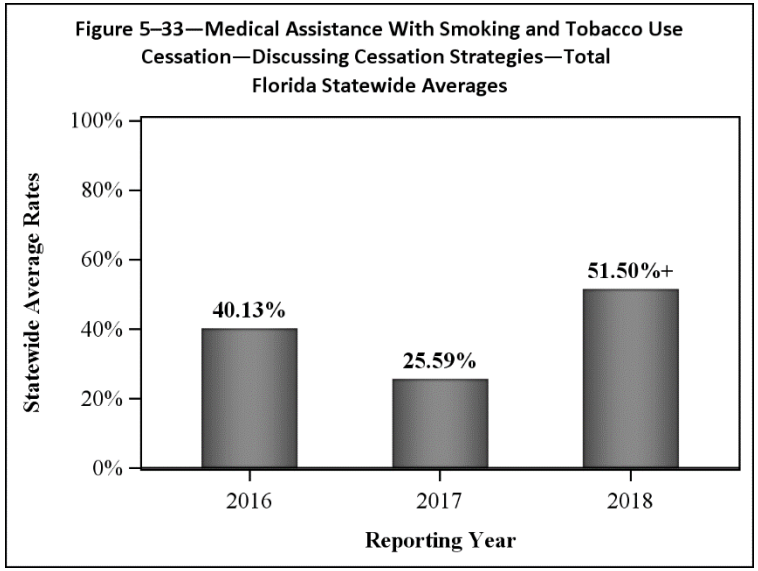
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<100) to report a valid rate.

All six MMA plans with reportable rates ranked above the national Medicaid 50th percentile, with four MMA plans and the statewide average ranking above the HPL. MMA plan performance varied by nearly 20 percentage points.

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total

Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total assesses the percentage of enrollees 18 years of age or older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year. The rates for this measure were weighted by the number of survey respondents (i.e., denominator) rather than the eligible population; therefore, exercise caution when comparing plan performance.

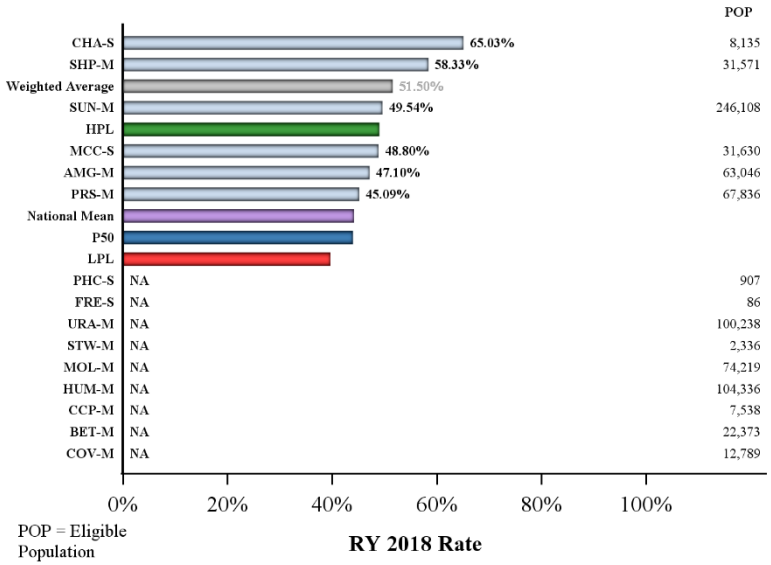
Figure 5–33—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 5–34—Medical Assistance With Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total
Health Plan Ranking

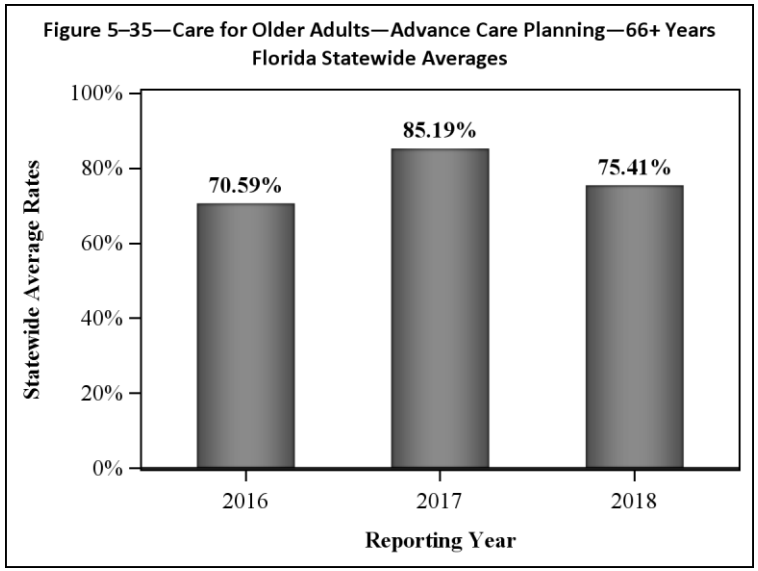


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<100) to report a valid rate.

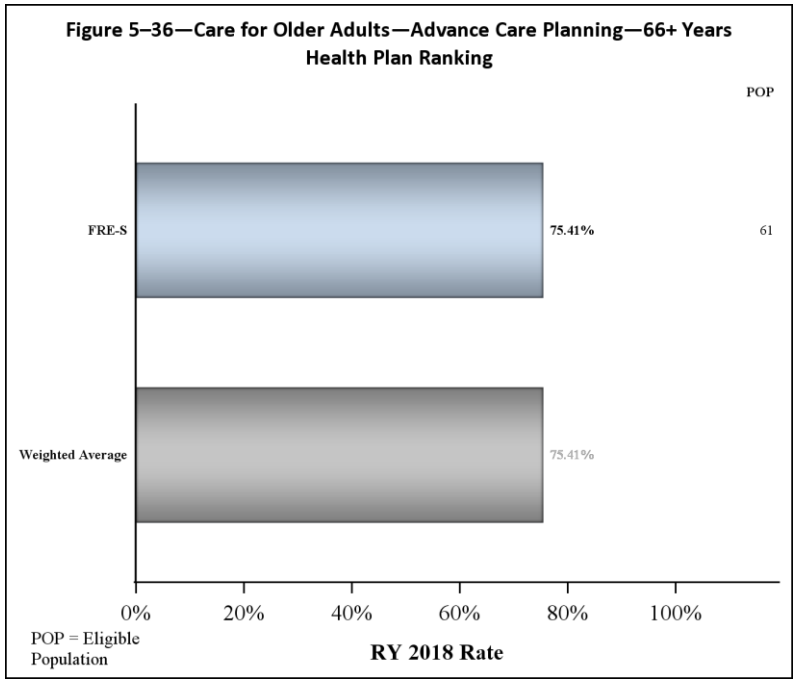
All six MMA plans with reportable rates ranked above the national Medicaid 50th percentile, with three MMA plans and the statewide average ranking above the HPL. MMA plan performance varied by nearly 20 percentage points.

Care for Older Adults—Advance Care Planning—66+ Years

Care for Older Adults—Advance Care Planning—66+ Years assesses the percentage of enrollees 66 years of age or older who had evidence of advance care planning during the measurement year.



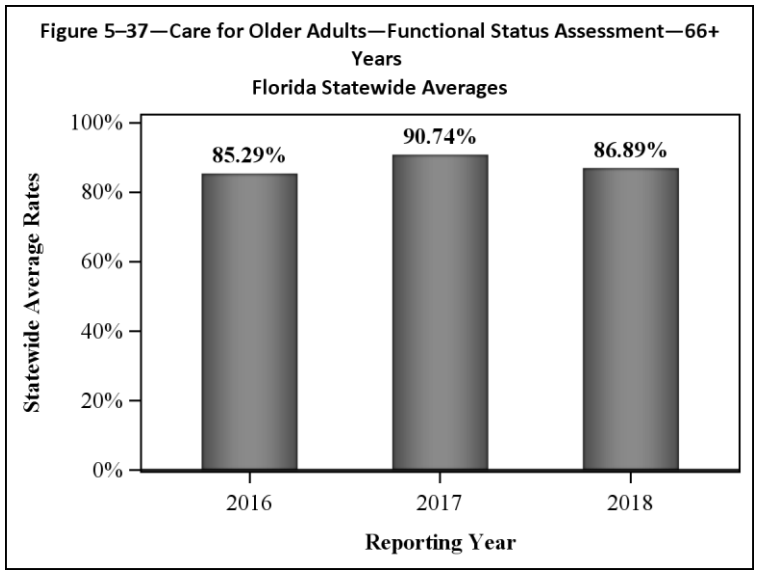
The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.



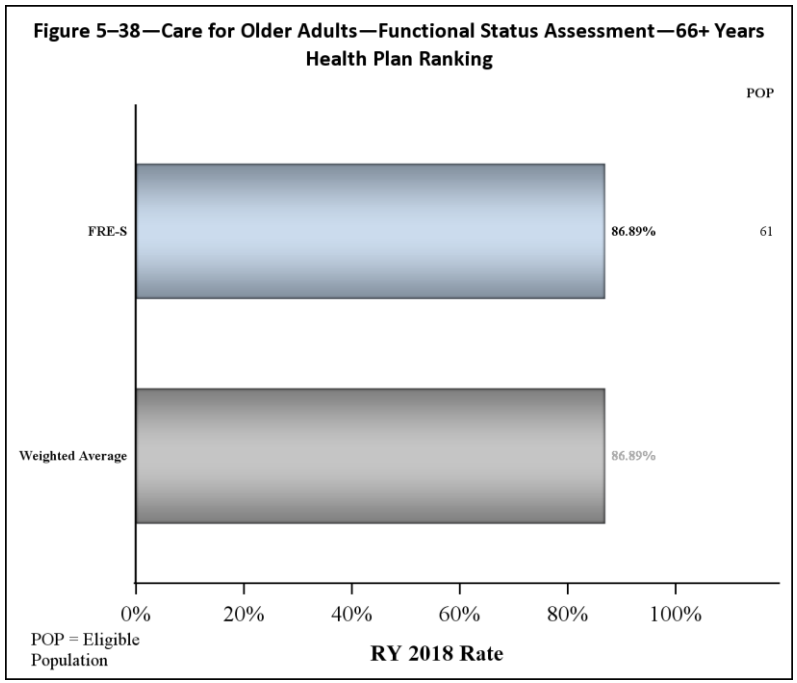
AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only.

Care for Older Adults—Functional Status Assessment—66+ Years

Care for Older Adults—Functional Status Assessment—66+ Years assesses the percentage of enrollees 66 years of age or older who received at least one functional status assessment during the measurement year.



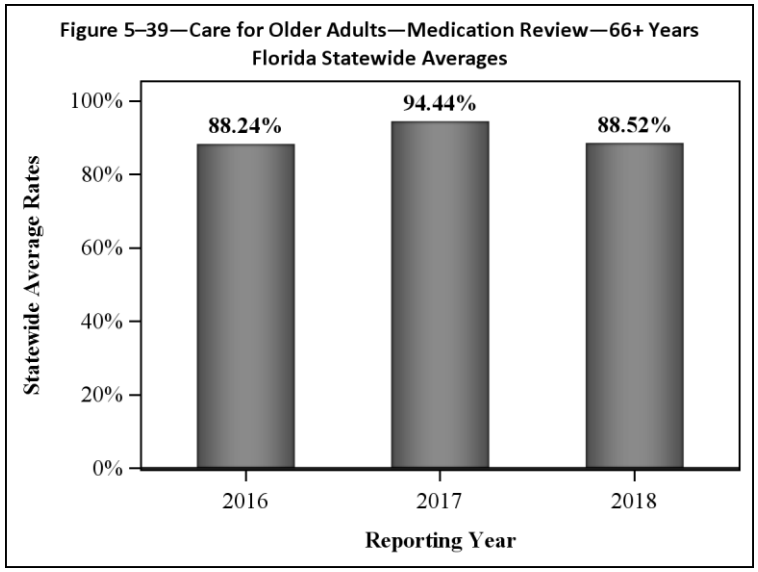
The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.



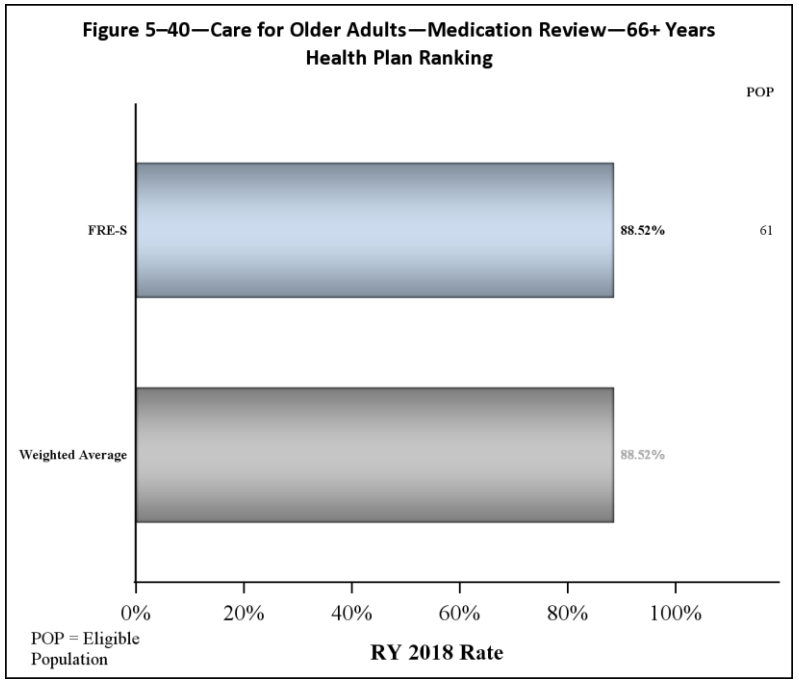
AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only.

Care for Older Adults—Medication Review—66+ Years

Care for Older Adults—Medication Review—66+ Years assesses the percentage of enrollees 66 years of age or older who received at least one medication review, including the presence of a medication list, or who received transitional care management services during the measurement year.



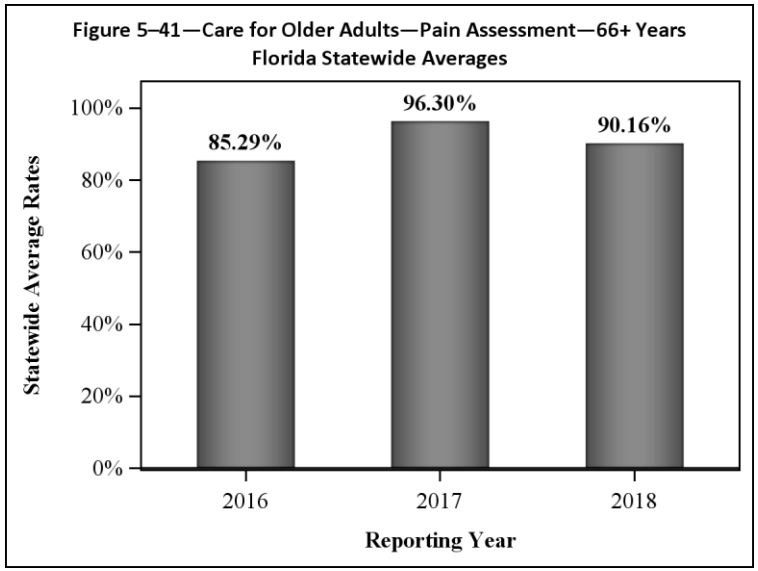
The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.



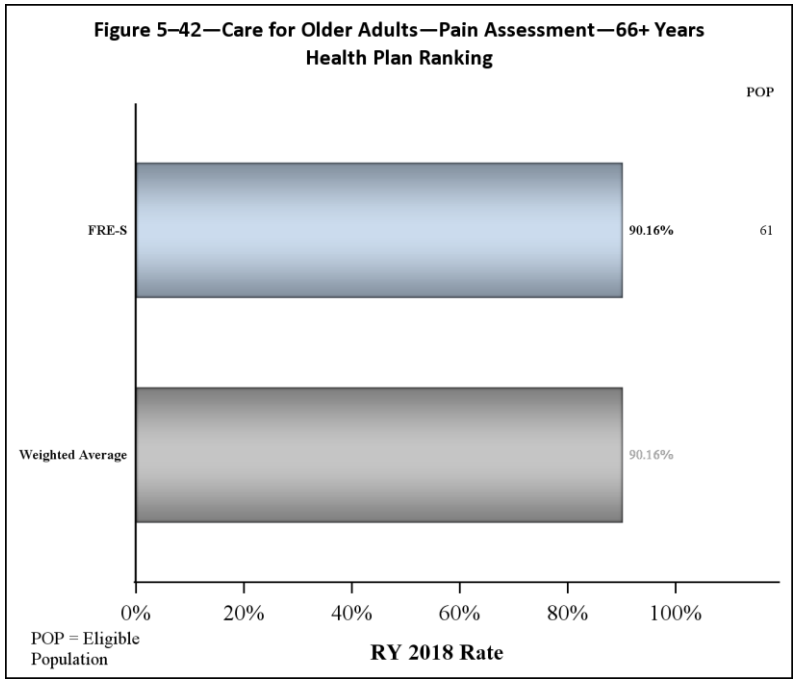
AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only.

Care for Older Adults—Pain Assessment—66+ Years

Care for Older Adults—Pain Assessment—66+ Years assesses the percentage of enrollees 66 years of age or older who received at least one pain assessment during the measurement year.



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.



AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only.

13. Behavioral Health

Introduction

The Behavioral Health measure domain encompasses the following measures reported by the Standard and Specialty MMA plans:

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total* and *Engagement of AOD Treatment—Total—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*
- *Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*
- *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*
- *Mental Health Readmission Rate*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented in this section. For reference, additional analyses for each measure indicator are displayed in Appendix D.

Summary of Findings

Table 13-1 presents the statewide average performance for the measure indicators under the Behavioral Health measure domain. The table lists the RY 2018 statewide average and performance levels, a comparison of the RY 2017 to the RY 2018 statewide average for each measure indicator with trend analysis results, and a summary of the MMA plans with rates demonstrating statistically significant changes from RY 2017 to RY 2018.

Table 13-1—RY 2018 Statewide Performance Levels and Trend Results for Behavioral Health

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of MMA Plans With Statistically Significant Improvement in RY 2018	Number of MMA Plans With Statistically Significant Decline in RY 2018
Initiation and Engagement of AOD Abuse or Dependence Treatment[3]				
Initiation of AOD Treatment—Total—Total	41.80%	NC	NC	NC
Engagement of AOD Treatment—Total—Total	6.90%	NC	NC	NC
Follow-Up After Hospitalization for Mental Illness[3]				
7-Day Follow-Up	30.52%	NC	NC	NC
30-Day Follow-Up	51.14%	NC	NC	NC
Follow-Up After ED Visit for Mental Illness[4,5]				
7-Day Follow-Up	28.05%	**-5.00**$^{++}$	2	3
30-Day Follow-Up	45.22%	**-5.92**$^{++}$	1	3
Follow-Up After ED Visit for AOD Abuse or Dependence[4,5]				
7-Day Follow-Up—Total	5.52%	**-4.17**$^{++}$	0	5
30-Day Follow-Up—Total	8.21%	**-4.09**$^{++}$	0	4
Antidepressant Medication Management[4]				
Effective Acute Phase Treatment	52.58%	+1.20	2	1
Effective Continuation Phase Treatment	37.21%	**+1.49**$^{+}$	2	1
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	62.68%	-0.63	1	2
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	38.90%	+0.84	3	0
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
*Total**	1.71%	+0.07	0	1
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[4]				
Total	62.12%	NC	NC	NC
Mental Health Readmission Rate				
*Mental Health Readmission Rate**	40.92%	**+7.40**$^{++}$	1	12
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.75%	+0.13	0	1

[1] *2018 performance levels were based on comparisons of the RY 2018 statewide average measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks. 2018 performance levels represent the following percentile comparisons:*

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] RY 2017 statewide average to RY 2018 statewide average comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

[3] Due to changes in the technical specifications for this measure in RY 2018, trending between 2018 and prior years is not recommended; therefore, comparisons to the prior year's rates and benchmarks are not performed for this measure.

[4] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.

[5]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Follow-Up After ED Visit for Mental Illness and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which was compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

** For this indicator, a lower rate indicates better performance.*

Green Shading[+] *Indicates that the RY 2018 statewide average demonstrated a statistically significant improvement from the RY 2017 statewide average.*

Red Shading[++] *Indicates that the RY 2018 statewide average demonstrated a statistically significant decline from the RY 2017 statewide average.*

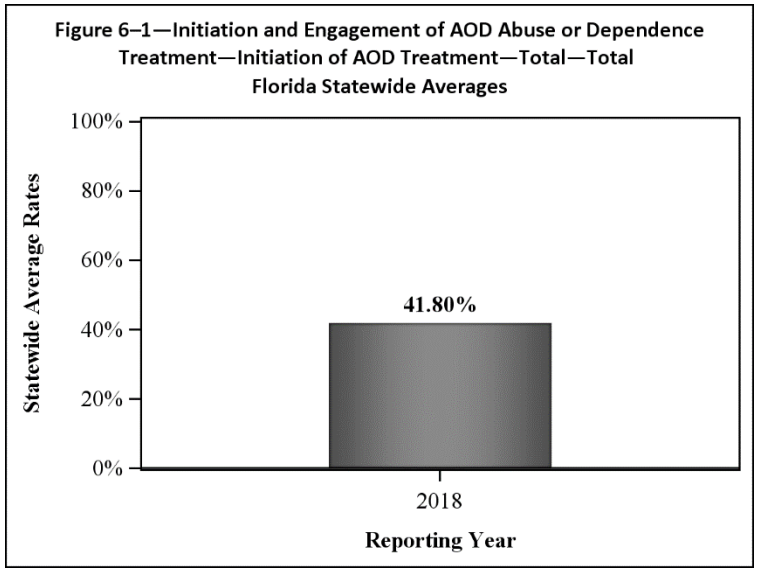
Table 13-1 shows that for the Behavioral Health domain, one of 11 statewide average rates (approximately 9 percent) that could be compared to the prior year's rates demonstrated a significant increase from RY 2017 to RY 2018.

Conversely, five of 11 statewide average rates (approximately 45 percent) that could be compared to national Medicaid percentiles fell below the national Medicaid 50th percentile. Additionally, the statewide average and 12 MMA plans demonstrated significant declines in performance for the *Mental Health Readmission Rate* in RY 2018. Of note, the *Follow-Up After ED Visit for Mental Illness* and *Follow-Up After ED Visit for AOD Abuse or Dependence* measures present opportunities for improvement, as the statewide averages for all four indicators were below the national Medicaid 25th percentile and demonstrated significant declines. Additionally, although caution should be exercised when trending these measures due to changes to the technical specifications, NCQA states that trending can still be performed. Further, the addition of telehealth to conduct appropriate follow-up visits should increase the rates. Given that the rates had significant declines over the prior year, the declines are most likely due to an actual decrease in performance; therefore, the comparison to the prior year is valid.

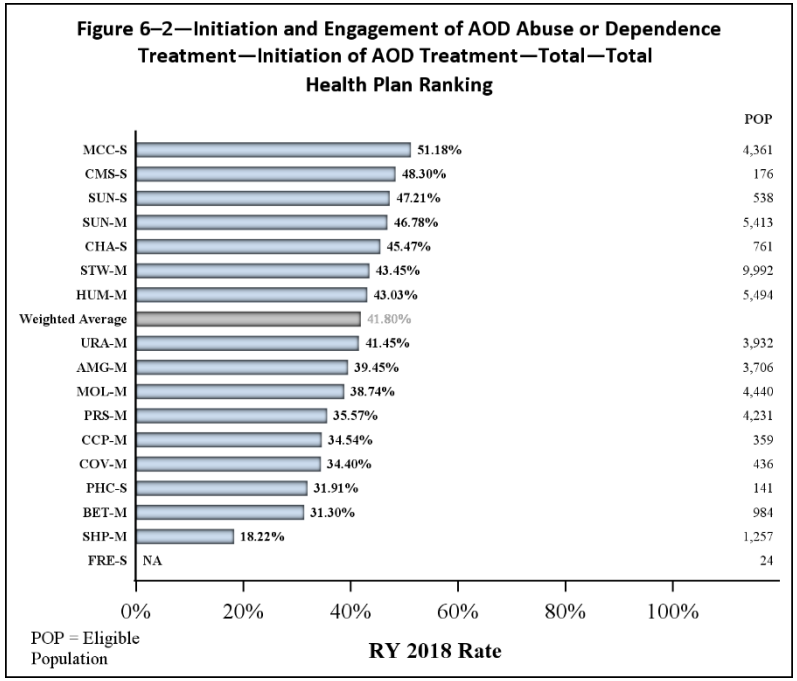
Measure-Specific Findings

Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total

The *Initiation of AOD Treatment—Total—Total* indicator assesses the percentage of enrollees 13 years of age and older with a new episode of AOD abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of diagnosis.



Due to changes to the RY 2018 technical specifications for this measure indicator, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed.



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

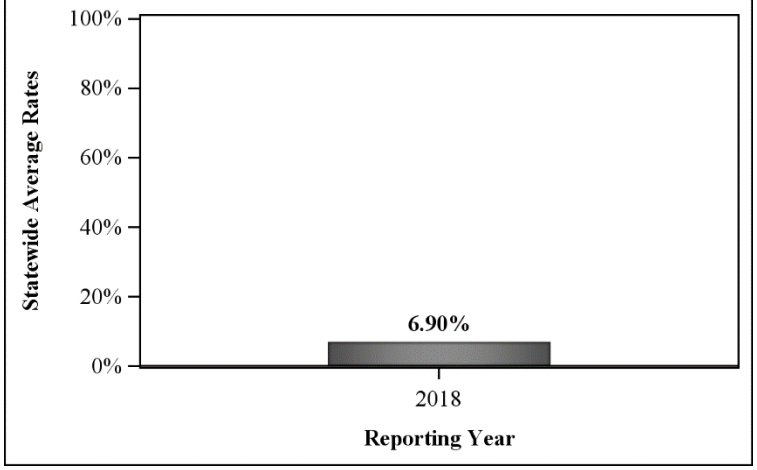
Due to changes in the technical specifications in RY 2018 for this indicator, a comparison to benchmarks is not appropriate. The rates in the chart above are presented for

information only. MMA plan performance varied by nearly 35 percentage points.

Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total

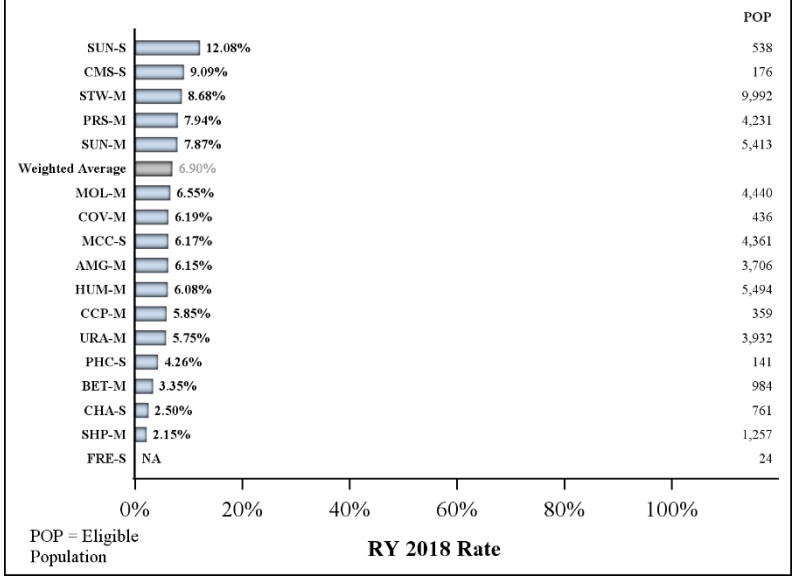
The *Engagement of AOD Treatment—Total—Total* indicator assesses the percentage of enrollees 13 years of age and older with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the diagnosis.

Figure 6–3—Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total
Florida Statewide Averages



Due to changes to the RY 2018 technical specifications for this measure indicator, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed.

Figure 6–4—Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total
Health Plan Ranking



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

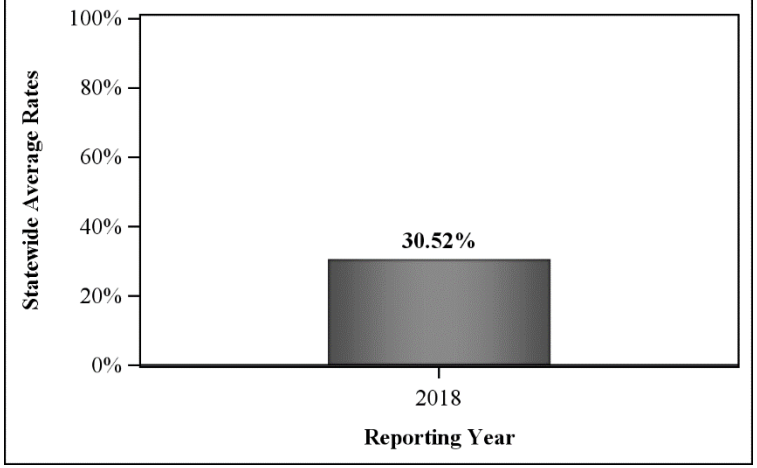
Due to changes in the technical specifications in RY 2018 for this indicator, a comparison to benchmarks is not appropriate. The rates in the chart above are presented for

information only. MMA plan performance varied by almost 10 percentage points.

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up

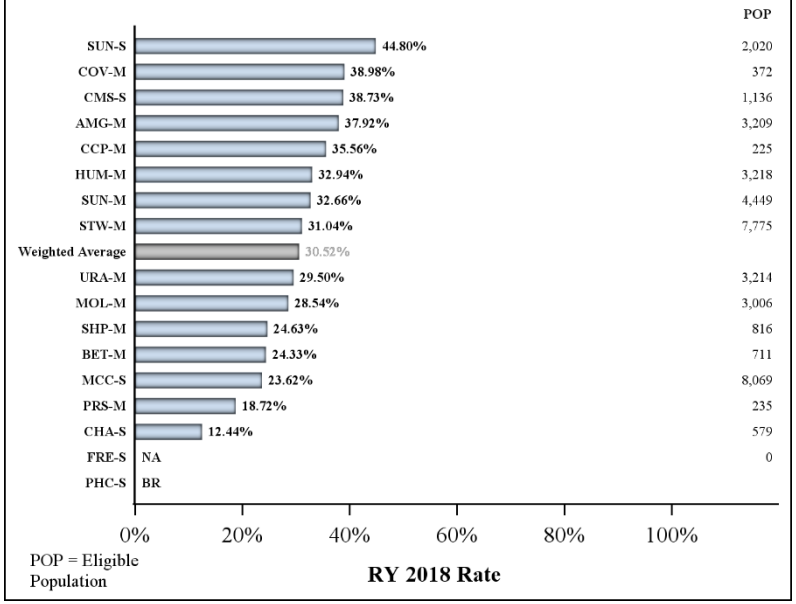
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up assesses the percentage of enrollees who were hospitalized for a mental illness who had a follow-up visit with a mental health practitioner within 7 days after discharge.

Figure 6–5—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up
Florida Statewide Averages



Due to changes to AHCA's performance measure specifications for this measure, trending is not recommended between 2018 and prior years; therefore, prior year statewide average rates are not displayed.

Figure 6–6—Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up
Health Plan Ranking



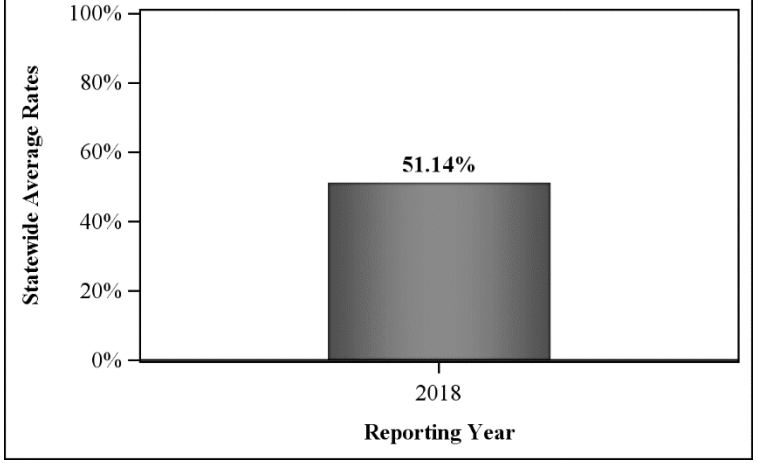
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR indicates that the MHP's reported rate was invalid; therefore, the rate was not presented.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by over 30 percentage points.

Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up

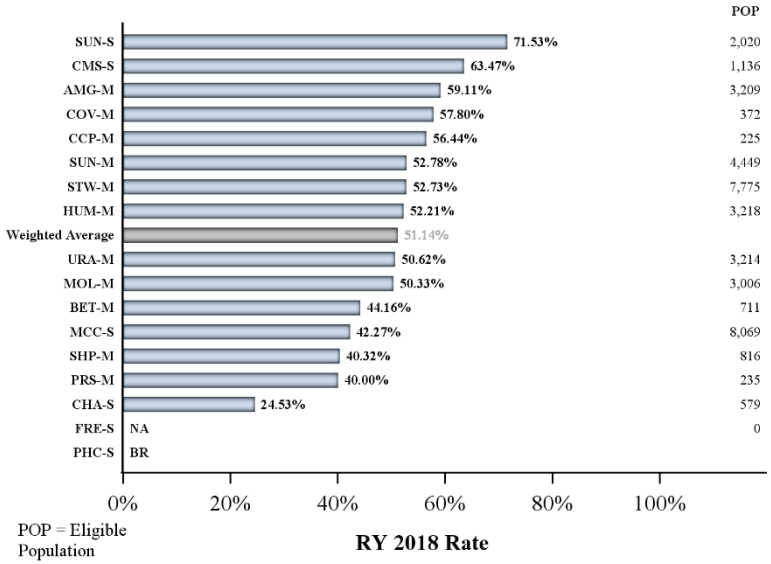
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up assesses the percentage of enrollees who were hospitalized for a mental illness who had a follow-up visit with a mental health practitioner within 30 days after discharge.

Figure 6–7—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up
Florida Statewide Averages



Due to changes to AHCA's performance measure specifications for this measure, trending is not recommended between 2018 and prior years; therefore, prior year statewide average rates are not displayed.

Figure 6–8—Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up
Health Plan Ranking

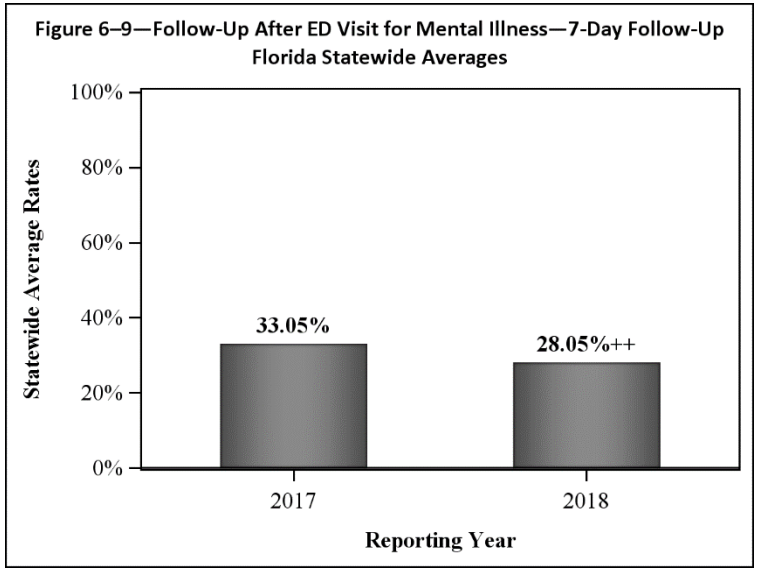


NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.
BR indicates that the MHP's reported rate was invalid; therefore, the rate was not presented.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by over 45 percentage points.

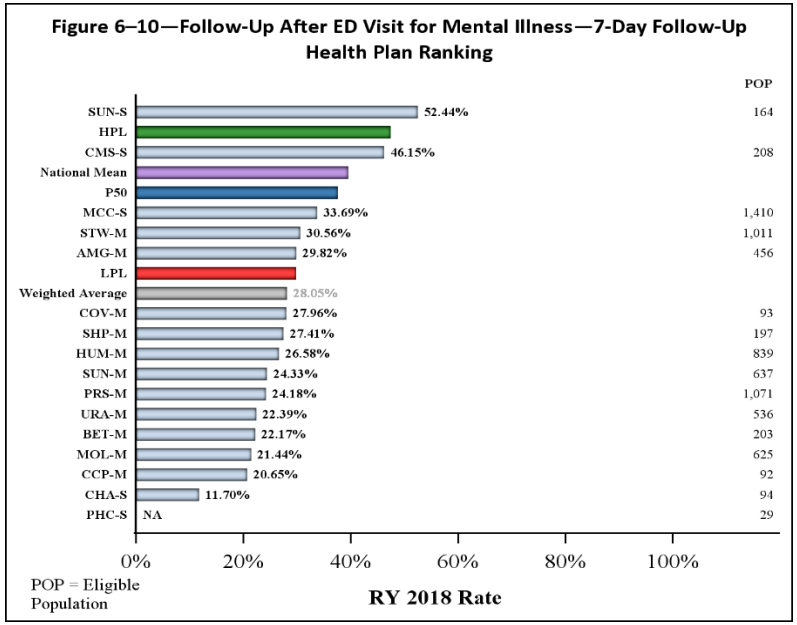
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up

Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up assesses the percentage of ED visits for enrollees 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 7 days of the ED visit. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2018 and prior years.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

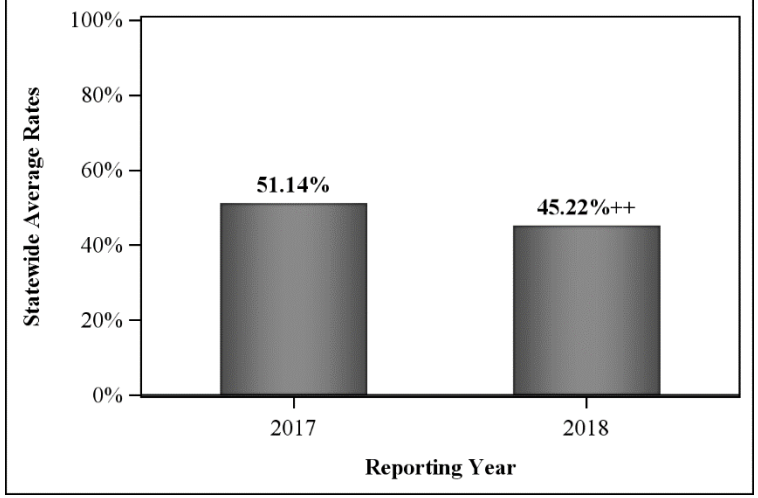
Quality Compass percentiles for this measure were not available; therefore, the rates for this measure indicator were compared to the NCQA Audit Means and Percentiles.

Two MMA plans ranked above the national Medicaid 50th percentile, with one plan ranking above the HPL. Ten MMA plans with reportable rates and the statewide average fell below the LPL. MMA plan performance varied by over 40 percentage points.

Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up

Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up assesses the percentage of ED visits for enrollees 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness within 30 days of the ED visit. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2018 and prior years.

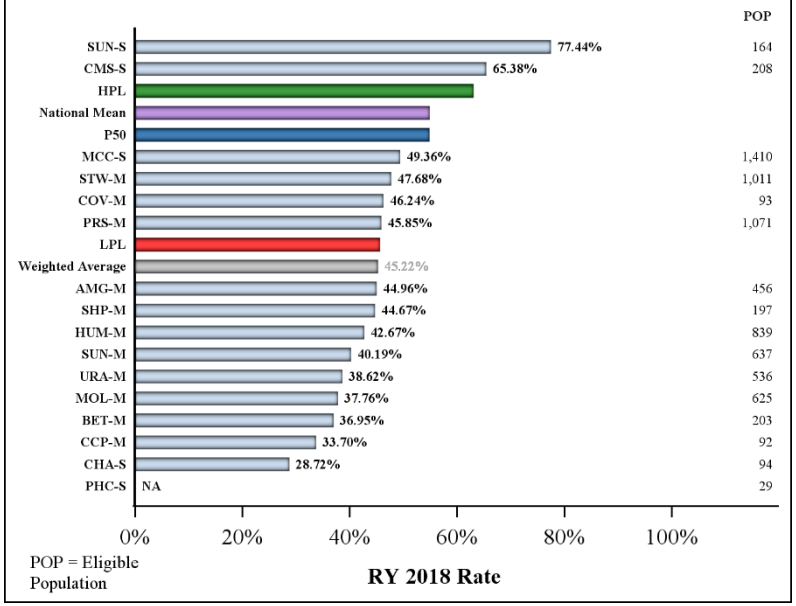
Figure 6–11—Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up
Florida Statewide Averages



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

Figure 6–12—Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up
Health Plan Ranking



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
Quality Compass percentiles for this measure were not available; therefore, the rates for this measure indicator were compared to the NCQA Audit Means and Percentiles.

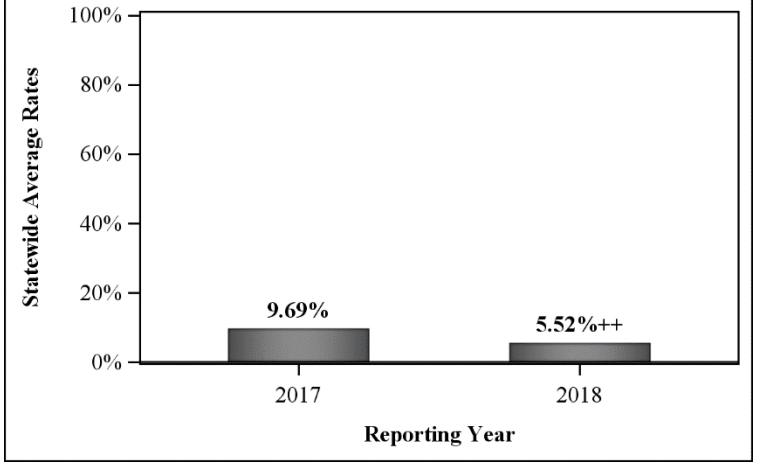
Two MMA plans ranked above the national Medicaid 50th percentile and the HPL. Nine MMA plans with reportable

rates and the statewide average fell below the LPL. MMA plan performance varied by nearly 50 percentage points.

Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total

Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total assesses the percentage of ED visits for enrollees 13 years of age and older with a principal diagnosis of AOD abuse or dependence, who had a follow-up visit for AOD within 7 days of the ED visit. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2018 and prior years.

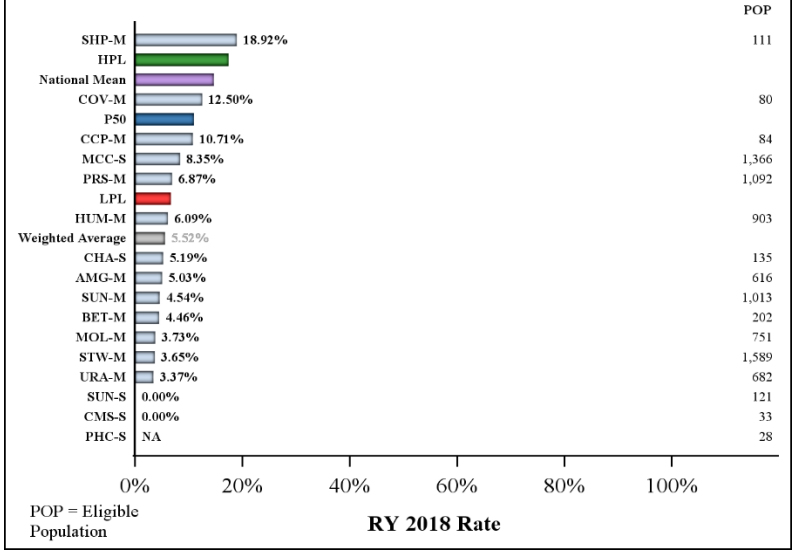
Figure 6–13—Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total
Florida Statewide Averages



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

Figure 6–14—Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total
Health Plan Ranking



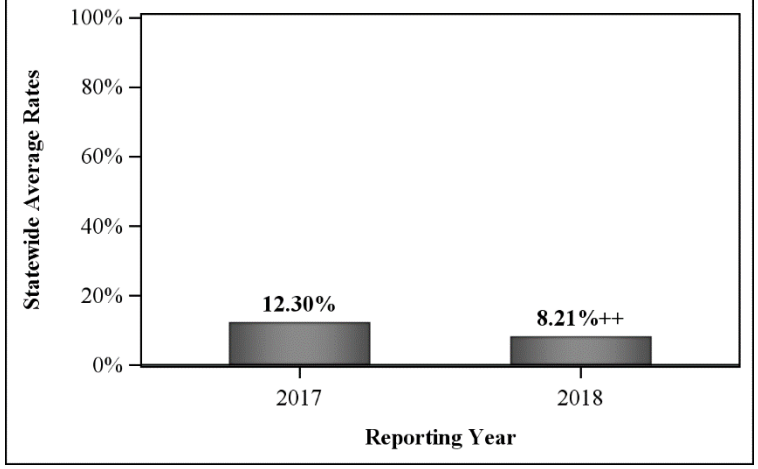
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
Quality Compass percentiles for this measure were not available; therefore, the rates for this measure indicator were compared to the NCQA Audit Means and Percentiles.

Two MMA plans ranked above the national Medicaid 50th percentile, with one MMA plan ranking above the HPL. Ten MMA plans with reportable rates and the statewide average fell below the LPL. MMA plan performance varied by nearly 20 percentage points.

Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total

Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total assesses the percentage of ED visits for enrollees 13 years of age and older with a principal diagnosis of AOD abuse or dependence, who had a follow-up visit for AOD within 30 days of the ED visit. Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2018 and prior years.

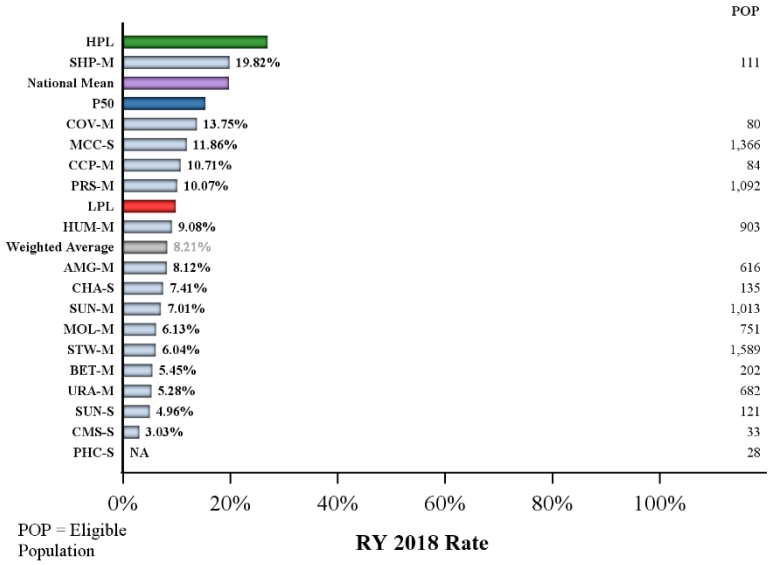
Figure 6–15—Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total
Florida Statewide Averages



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

Figure 6–16—Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total
Health Plan Ranking



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

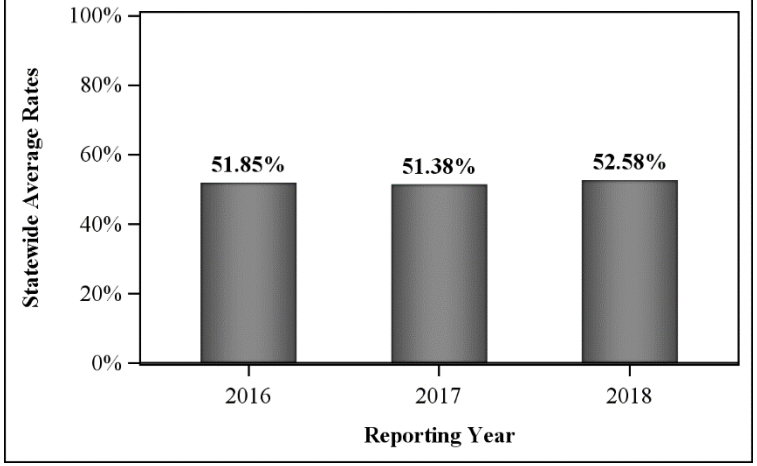
Quality Compass percentiles for this measure were not available; therefore, the rates for this measure indicator were compared to the NCQA Audit Means and Percentiles.

One MMA plan ranked above the national Medicaid 50th percentile. Ten MMA plans with reportable rates and the statewide average fell below the LPL. MMA plan performance varied by over 15 percentage points.

Antidepressant Medication Management—Effective Acute Phase Treatment

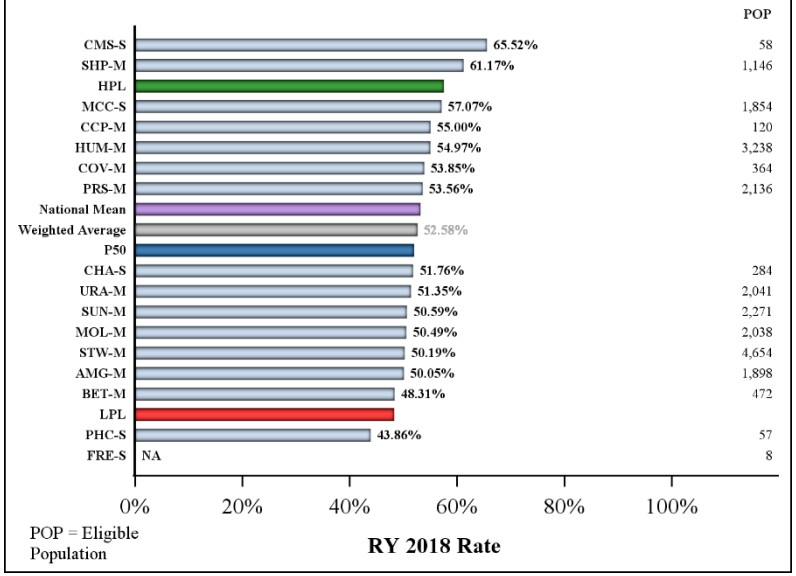
Antidepressant Medication Management—Effective Acute Phase Treatment assesses the percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2018 and prior years.

Figure 6–17—Antidepressant Medication Management—Effective Acute Phase Treatment
Florida Statewide Averages



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

Figure 6–18—Antidepressant Medication Management—Effective Acute Phase Treatment
Health Plan Ranking



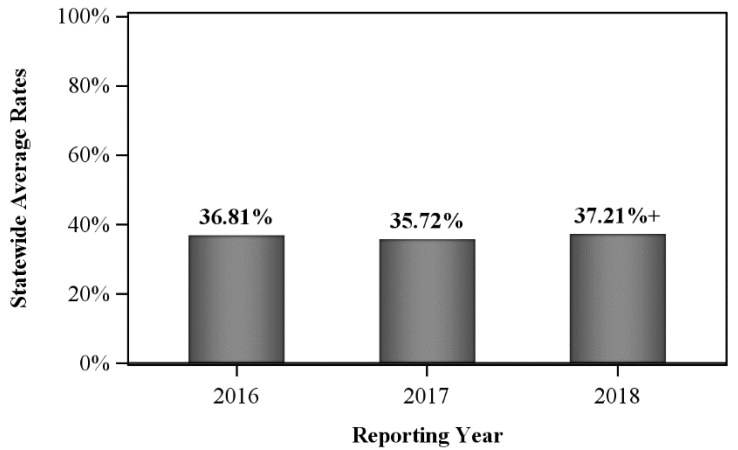
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Seven MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with two MMA plans ranking above the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by over 20 percentage points.

Antidepressant Medication Management—Effective Continuation Phase Treatment

Antidepressant Medication Management—Effective Continuation Phase Treatment assesses the percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for at least 180 days (6 months). Due to changes in the technical specifications for this measure indicator, exercise caution when trending rates between 2018 and prior years.

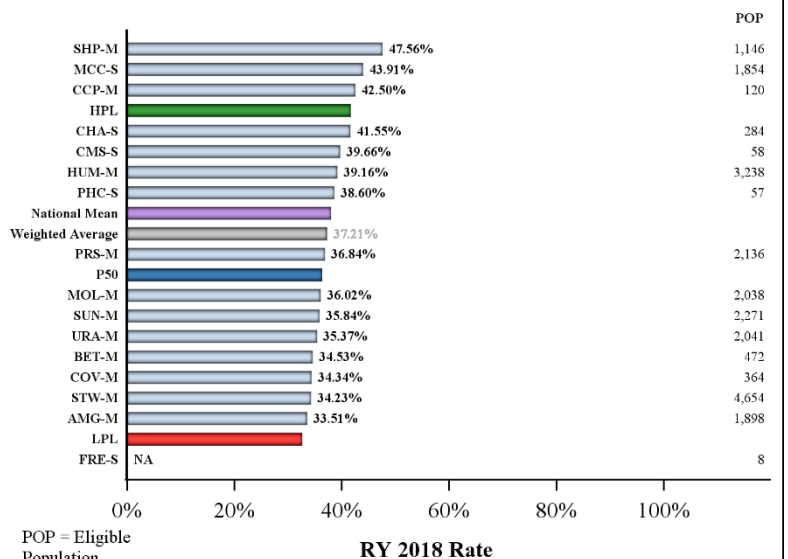
Figure 6–19—Antidepressant Medication Management—Effective Continuation Phase Treatment
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 6–20—Antidepressant Medication Management—Effective Continuation Phase Treatment
Health Plan Ranking



NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

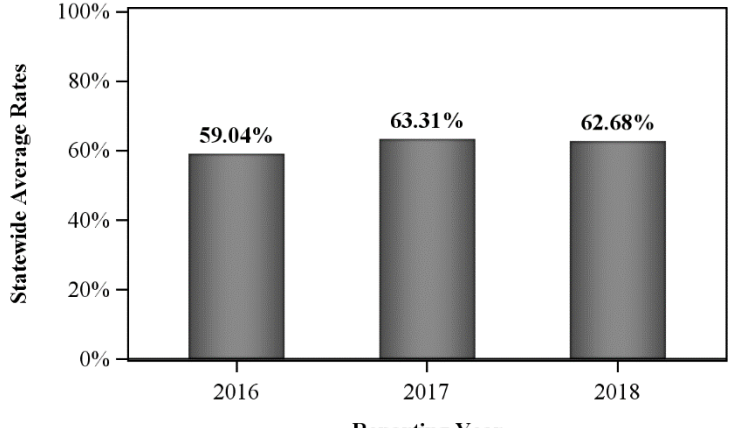
Eight MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with three MMA plans

ranking above the HPL. No MMA plans with reportable rates fell below the LPL. MMA plan performance varied by nearly 15 percentage points.

Adherence to Antipsychotic Medications for Individuals With Schizophrenia

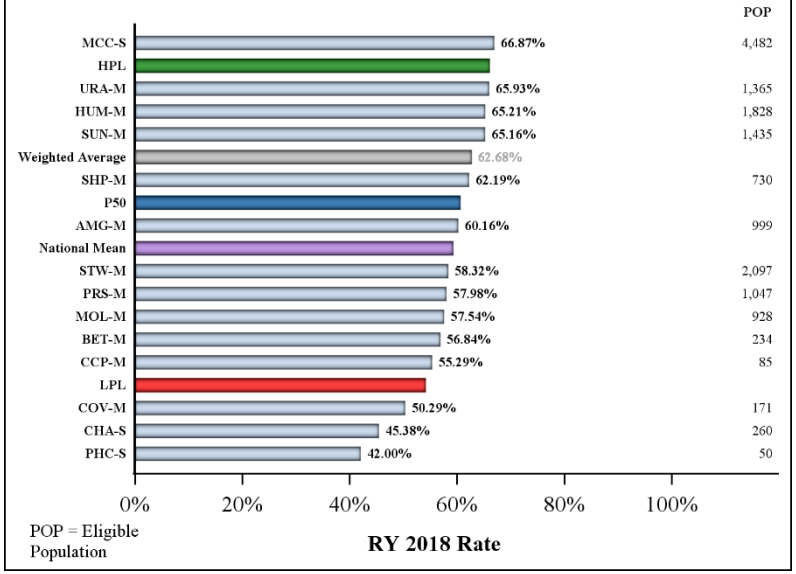
Adherence to Antipsychotic Medications for Individuals With Schizophrenia measures the percentage of enrollees between 19 and 64 years of age with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Figure 6–21—Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Florida Statewide Averages



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

Figure 6–22—Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Health Plan Ranking



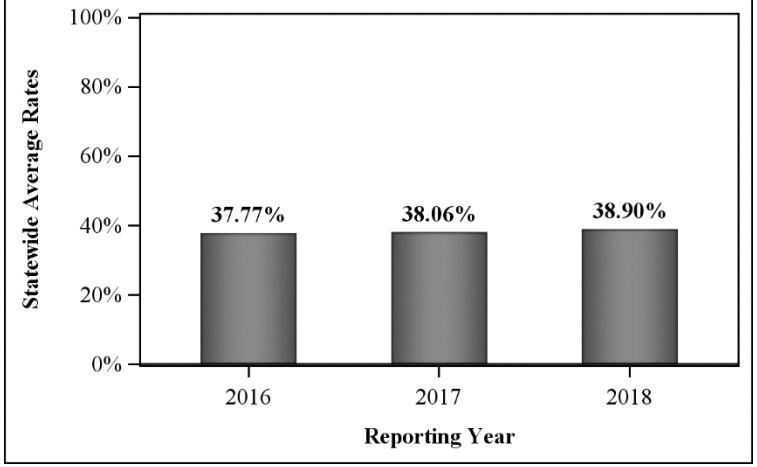
Five MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with one MMA plan ranking above the HPL. Three MMA plans fell below the

LPL. MMA plan performance varied by nearly 25 percentage points.

Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total

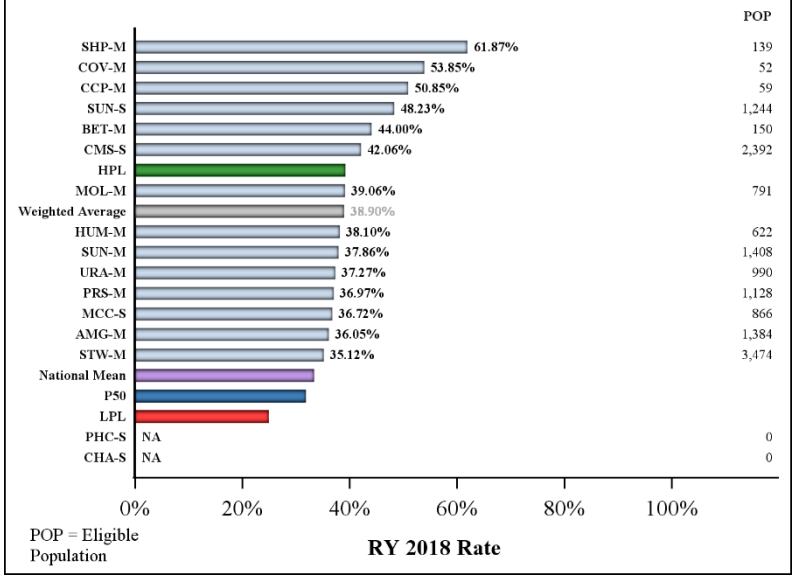
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total measures the percentage of enrollees 1 to 17 years of age who had two or more antipsychotic medication prescriptions and received metabolic testing.

Figure 6–23—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total
Florida Statewide Averages



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

Figure 6–24—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total
Health Plan Ranking

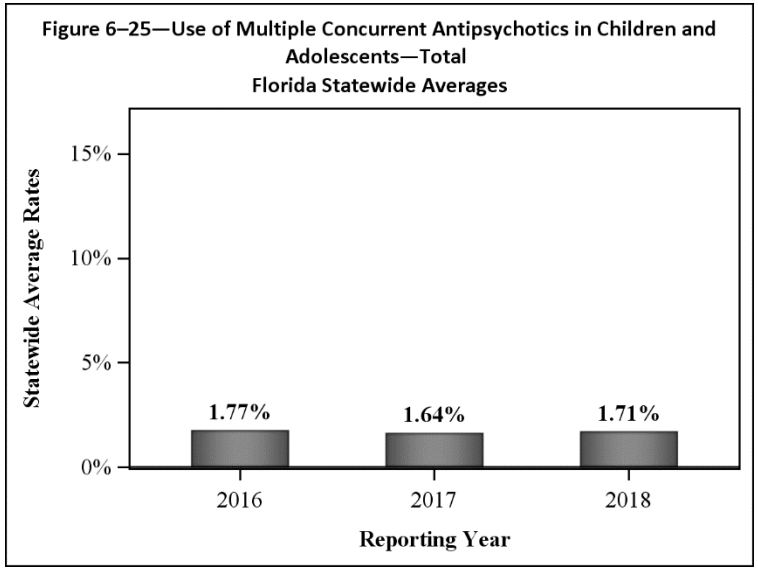


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

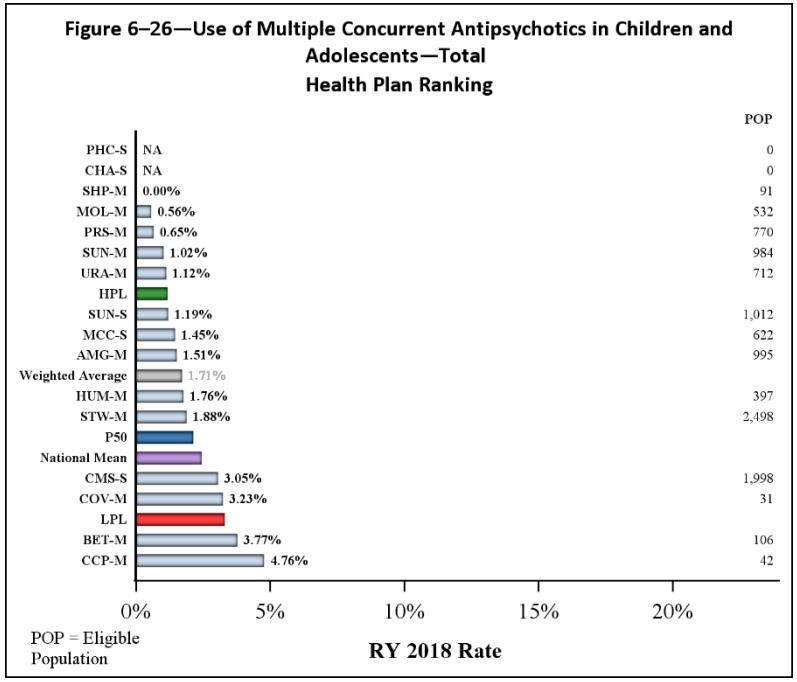
All 14 MMA plans with reportable rates and the statewide average ranked above the national Medicaid 50th percentile, with six MMA plans ranking above the HPL. MMA plan performance varied by over 25 percentage points.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total

Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total measures the percentage of enrollees 1 to 17 years of age who were on two or more concurrent antipsychotic medications for at least 90 consecutive days. For this indicator, a lower rate indicates better performance.



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.



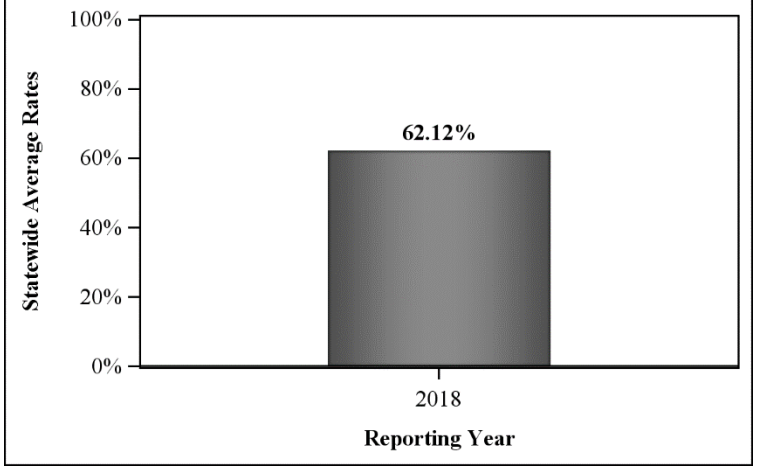
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Ten MMA plans with reportable rates and the statewide average ranked above the national Medicaid 50th percentile, with five MMA plans ranking above the HPL. Two MMA plans fell below the LPL. MMA plan performance varied by less than 5 percentage points.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total

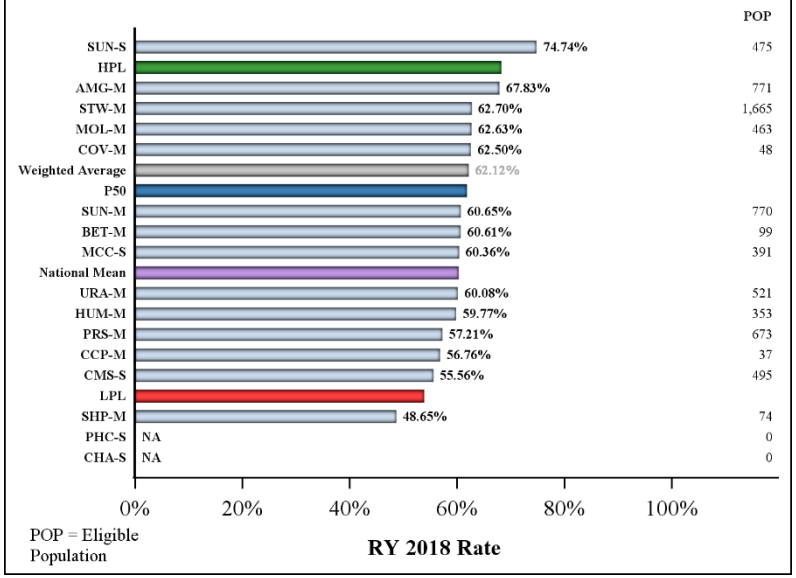
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total measures the percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Figure 6–27—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total
Florida Statewide Averages



This was the first year that the MMA plans reported rates for this measure; therefore, prior year statewide average rates are not available.

Figure 6–28—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total
Health Plan Ranking

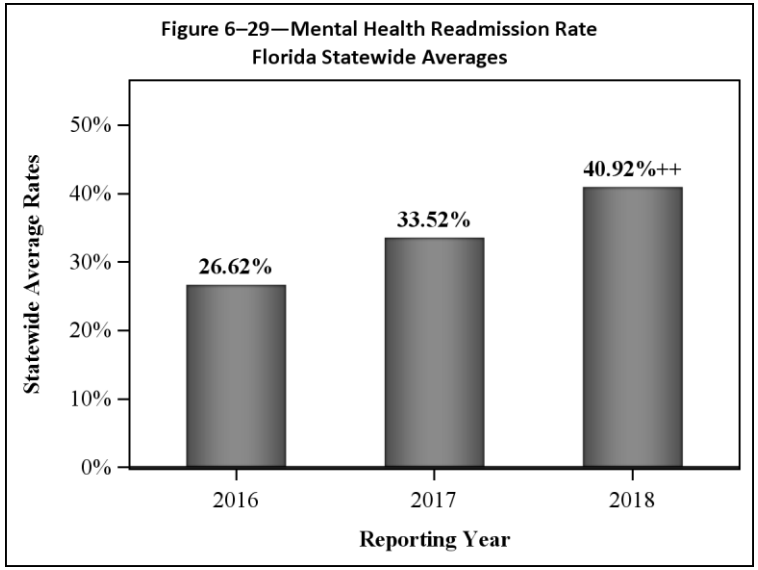


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Five MMA plans and the statewide average ranked above the national Medicaid 50th percentile, with one MMA plan ranking above the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by over 25 percentage points.

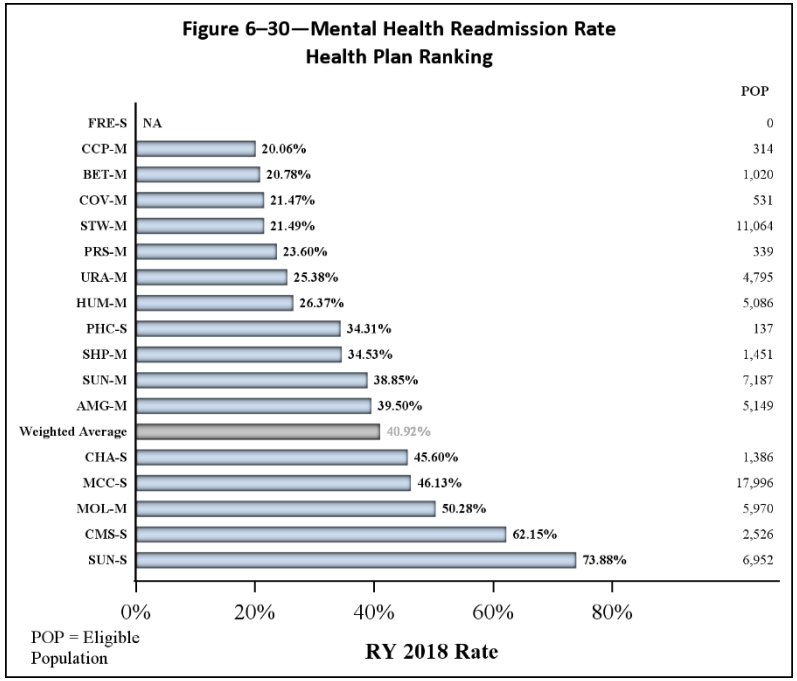
Mental Health Readmission Rate

Mental Health Readmission Rate measures the percentage of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis that resulted in a readmission due to a mental health diagnosis within 30 days. A lower rate indicates better performance for this measure.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly increased from RY 2017, representing a decline in performance as a lower rate indicates better performance for this measure.



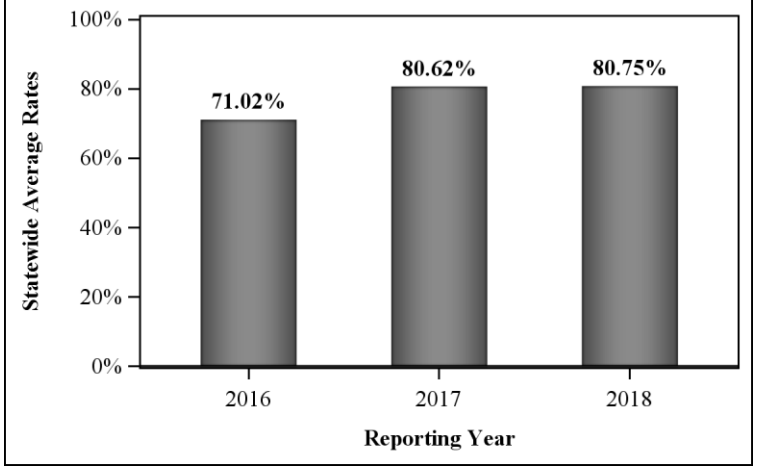
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. MMA plan performance varied by nearly 55 percentage points.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

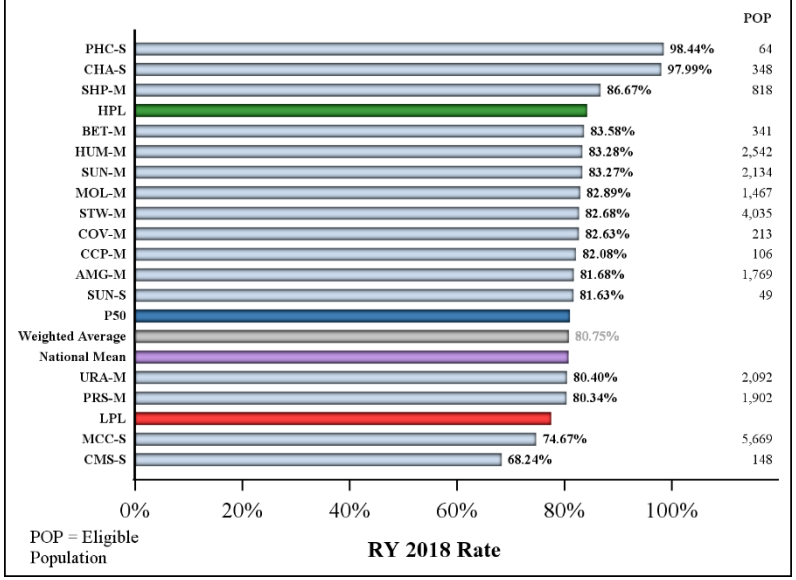
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measures the percentage of enrollees 18 to 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Figure 6–31—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Florida Statewide Averages



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

Figure 6–32—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Health Plan Ranking



Twelve MMA plans ranked above the national Medicaid 50th percentile, with three MMA plans ranking above the HPL. Two MMA plans fell below the LPL. MMA plan performance varied by over 30 percentage points.

14. Access/Availability of Care

Introduction

The Access/Availability of Care measure domain encompasses the following measures reported by the Standard and Specialty MMA plans:

- *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Call Answer Timeliness*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented in this section. For reference, additional analyses for each measure indicator are displayed in Appendix D.

Summary of Findings

Table 14-1 presents the statewide average performance for the measure indicators under the Access/Availability of Care measure domain. The table lists the RY 2018 statewide average and performance levels, a comparison of the RY 2017 to the RY 2018 statewide average for each measure indicator with trend analysis results, and a summary of the MMA plans with rates demonstrating statistically significant changes from RY 2017 to RY 2018.

Table 14-1—RY 2018 Statewide Performance Levels and Trend Results for Access/Availability of Care

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of MMA Plans With Statistically Significant Improvement in RY 2018	Number of MMA Plans With Statistically Significant Decline in RY 2018
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	94.62%	**+0.25⁺**	4	0
25 Months–6 Years	87.84%	+0.02	3	4
7–11 Years	88.21%	**-0.54⁺⁺**	2	5
12–19 Years	84.46%	**-0.70⁺⁺**	2	7
Adults' Access to Preventive/Ambulatory Health Services				
Total	75.50%	**+1.39⁺**	7	2
Call Answer Timeliness[3]				
Call Answer Timeliness	90.48%	**+2.78⁺**	12	4

[1] 2018 performance levels were based on comparisons of the RY 2018 statewide average measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks. 2018 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] RY 2017 statewide average to RY 2018 statewide average comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

[3] Current benchmarks are not available for this measure, as it was retired for RY 2017. Therefore, 2018 performance levels were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for RY 2015 (the most recent year available).

Green Shading⁺ *Indicates that the RY 2018 statewide average demonstrated a statistically significant improvement from the RY 2017 statewide average.*

Red Shading++ *Indicates that the RY 2018 statewide average demonstrated a statistically significant decline from the RY 2017 statewide average.*

Table 14-1 shows that for the Access/Availability of Care domain, three of six statewide average rates (50 percent) demonstrated significant increases from RY 2017 to RY 2018. Additionally, the statewide average for *Call Answer Timeliness* ranked above the national Medicaid 75th percentile and demonstrated a significant increase from RY 2017 to RY 2018, with 12 MMA plans demonstrating a significant improvement in RY 2018 for this measure.

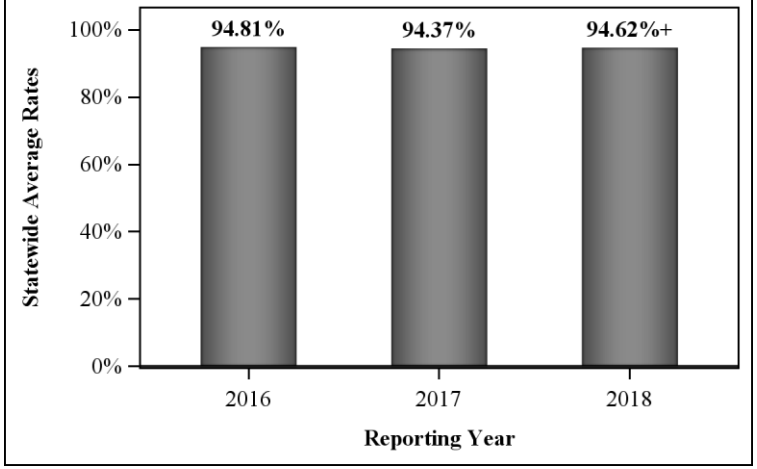
Conversely, five of six statewide average rates (approximately 83 percent) fell below the national Medicaid 50th percentile, with two statewide average rates (*Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* and *Adults' Access to Preventive/Ambulatory Health Services—Total*) falling below the national Medicaid 25th percentile. Additionally, the statewide average rates for *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years* fell below the 50th percentile and demonstrated significant declines from RY 2017 to RY 2018, further demonstrating opportunities to improve access to care for children and adults.

Measure-Specific Findings

Children and Adolescents' Access to Primary Care Practitioners—12–24 Months

Children and Adolescents' Access to Primary Care Practitioners—12–24 Months assesses the percentage of enrollees 12 to 24 months of age who had a visit with a PCP during the measurement year.

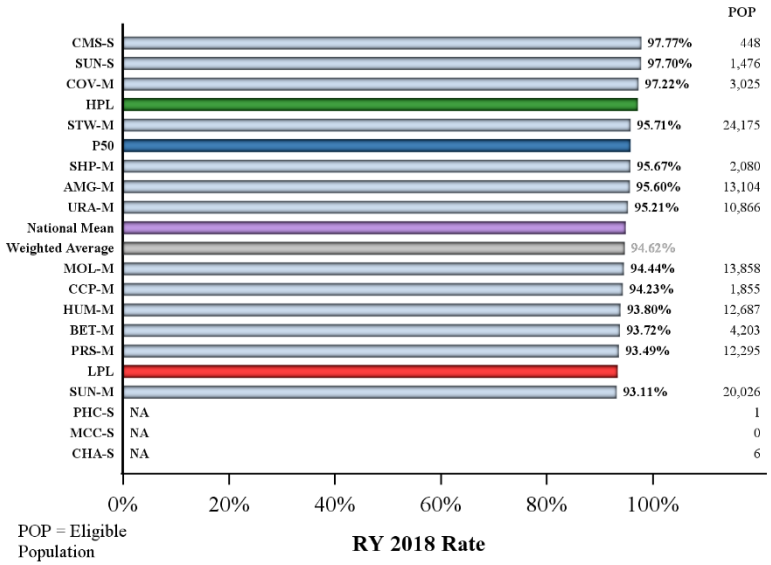
Figure 7–1—Children and Adolescents' Access to Primary Care Practitioners—12–24 Months
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 7–2—Children and Adolescents' Access to Primary Care Practitioners—12–24 Months
Health Plan Ranking

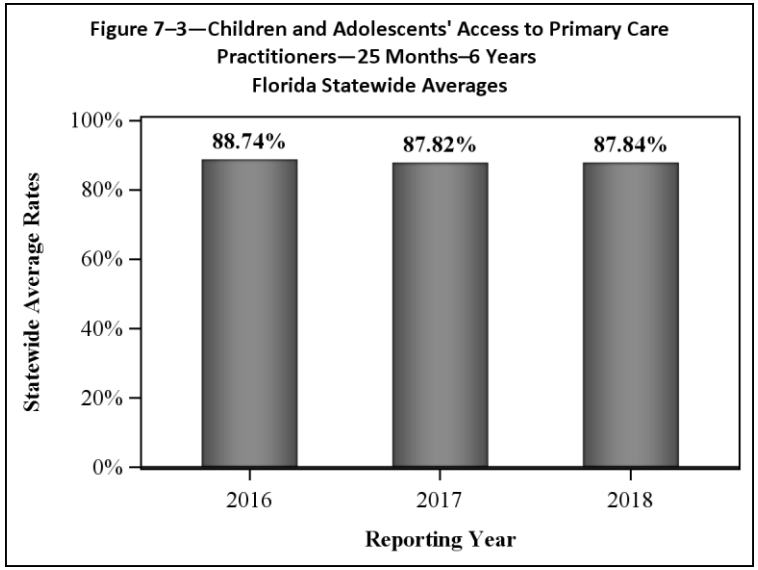


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

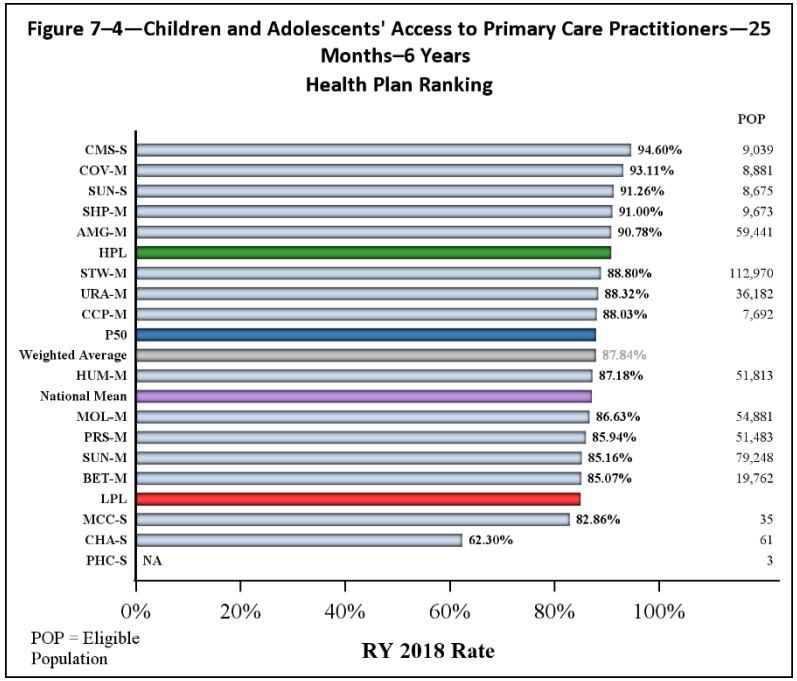
Four MMA plans ranked above the national Medicaid 50th percentile, with three MMA plans ranking above the HPL. One MMA plan with a reportable rate fell below the LPL. MMA plan performance varied by less than 5 percentage points.

Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years

Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years assesses the percentage of enrollees 25 months to 6 years of age who had a visit with a PCP during the measurement year.



The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

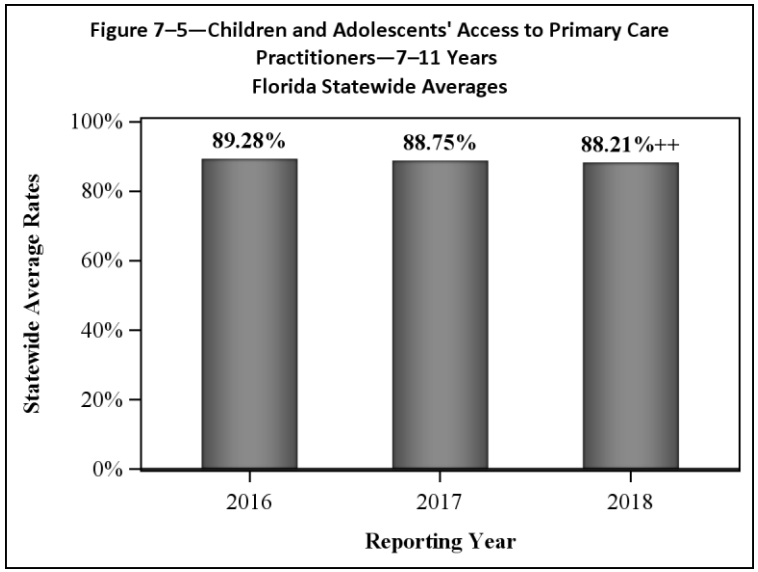


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Eight MMA plans ranked above the national Medicaid 50th percentile, with five MMA plans ranking above the HPL. Two MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 30 percentage points.

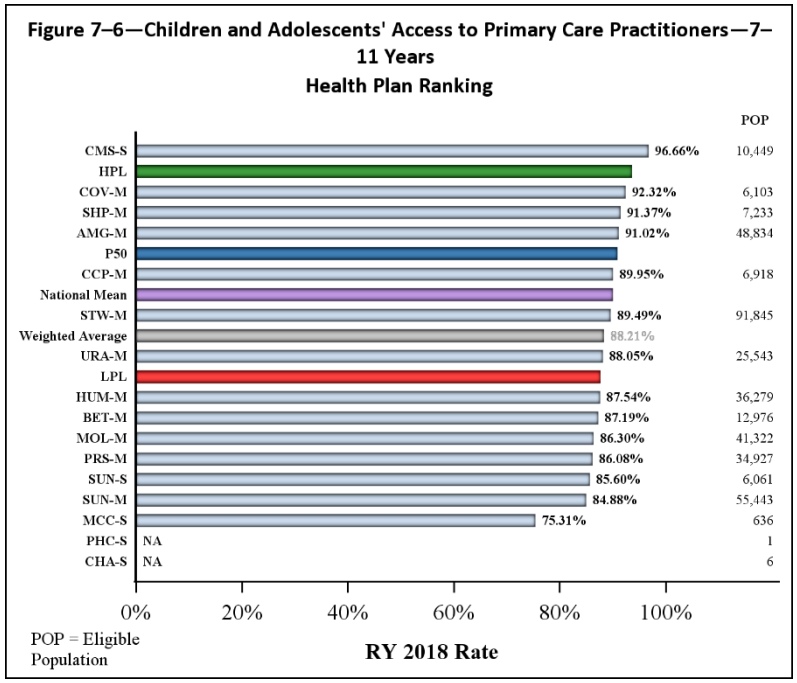
Children and Adolescents' Access to Primary Care Practitioners—7–11 Years

Children and Adolescents' Access to Primary Care Practitioners—7–11 Years assesses the percentage of enrollees 7 to 11 years of age who had a visit with a PCP during the measurement year.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

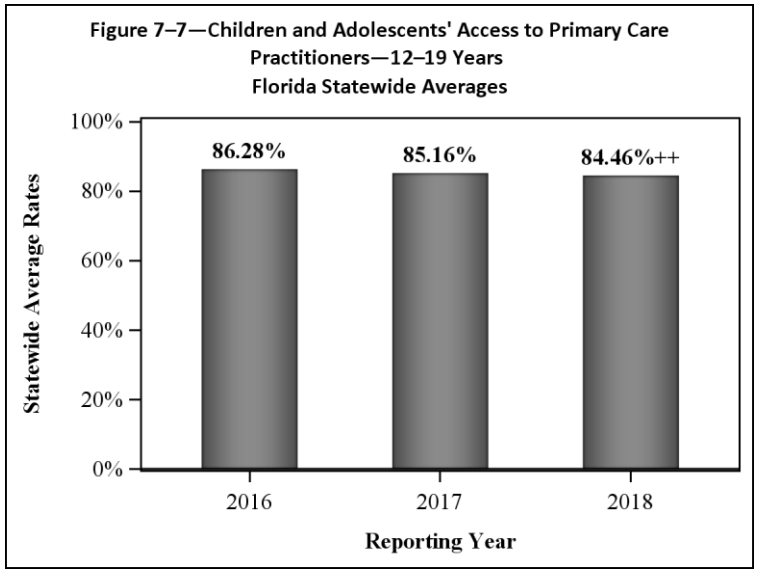


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Four MMA plans ranked above the national Medicaid 50th percentile, with one MMA plan ranking above the HPL. Seven MMA plans with reportable rates fell below the LPL. MMA plan performance varied by over 20 percentage points.

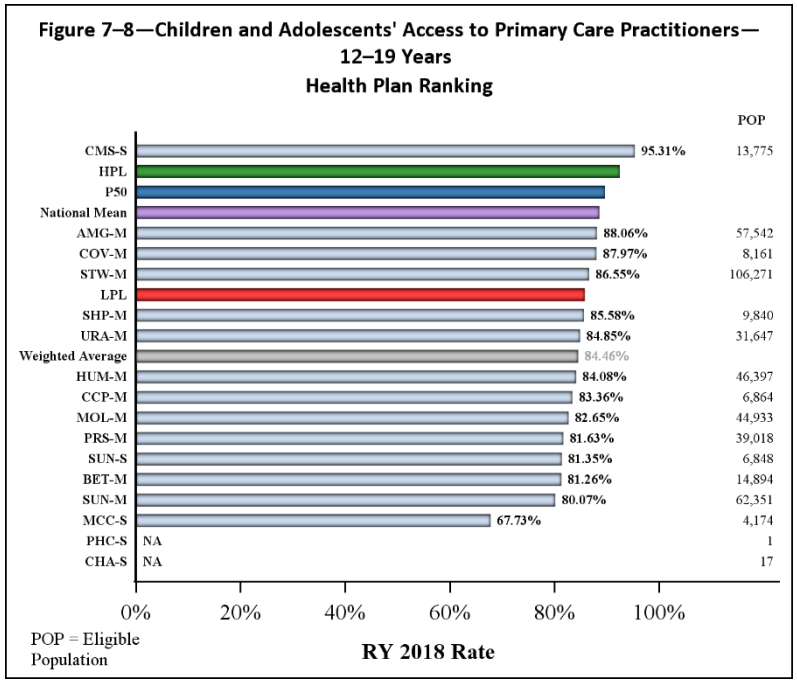
Children and Adolescents' Access to Primary Care Practitioners—12–19 Years

Children and Adolescents' Access to Primary Care Practitioners—12–19 Years assesses the percentage of enrollees 12 to 19 years of age who had a visit with a PCP during the measurement year.



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

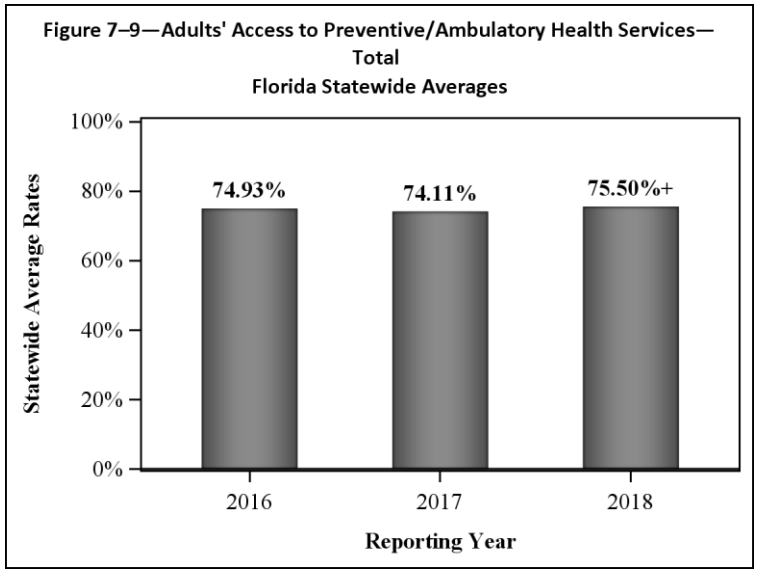


NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MMA plan ranked above the national Medicaid 50th percentile and the HPL. Ten MMA plans with reportable rates and the statewide average fell below the LPL. MMA plan performance varied by nearly 30 percentage points.

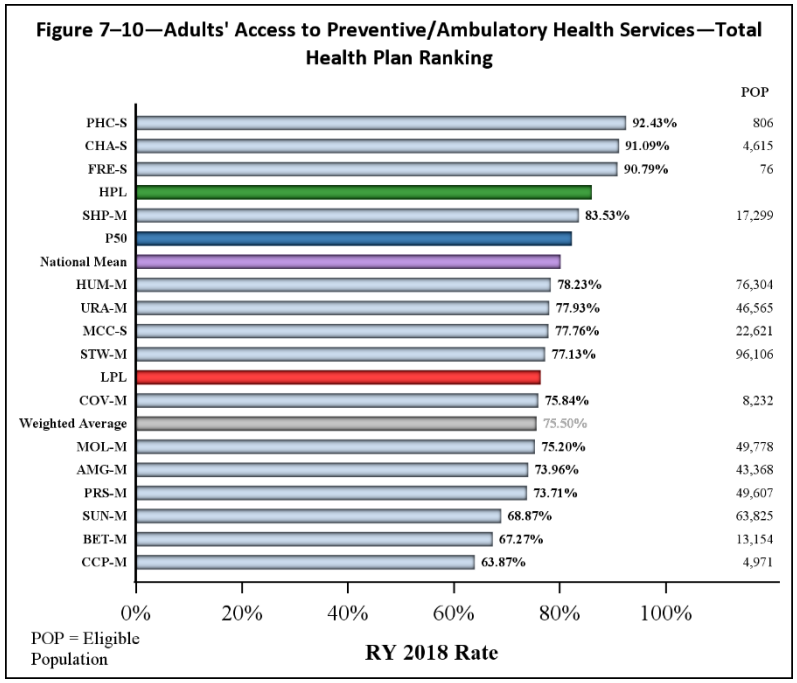
Adults' Access to Preventive/Ambulatory Health Services—Total

Adults' Access to Preventive/Ambulatory Health Services—Total assesses the percentage of enrollees 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

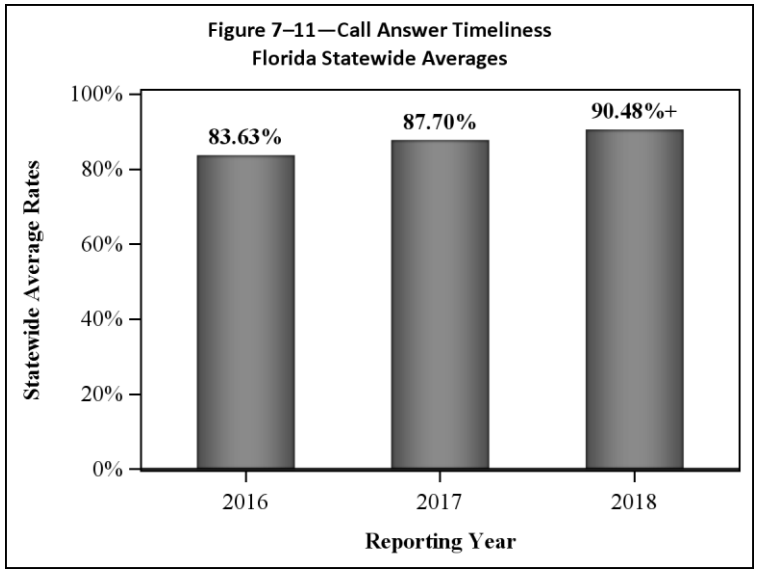
The RY 2018 statewide average rate significantly improved from RY 2017.



Four MMA plans ranked above the national Medicaid 50th percentile, with three MMA plans ranking above the HPL. Seven MMA plans and the statewide average fell below the LPL. MMA plan performance varied by nearly 30 percentage points.

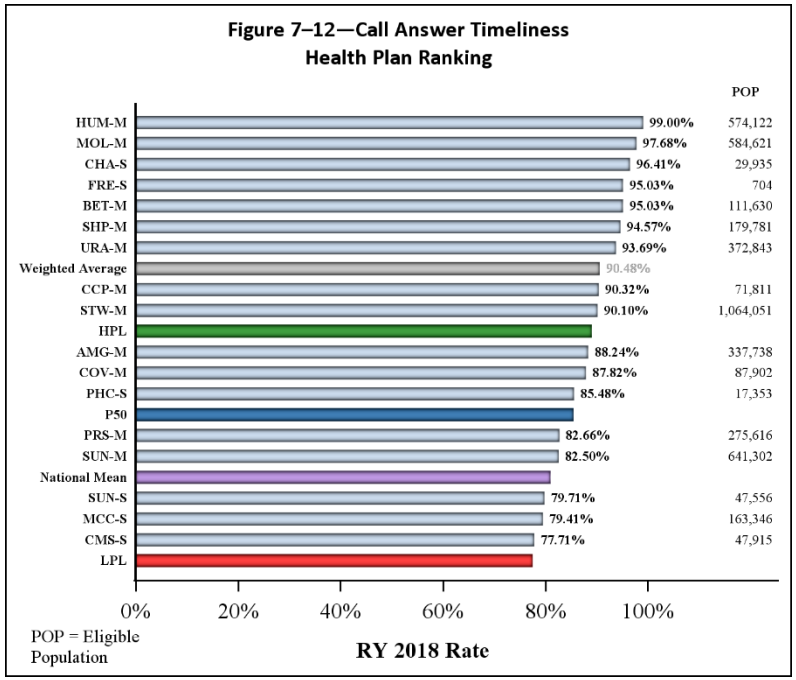
Call Answer Timeliness

Call Answer Timeliness assesses the percentage of calls received during the measurement year by the MMA plans' enrollee services call centers (during operating hours) that were answered by a live voice within 30 seconds.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



Twelve MMA plans ranked above the national Medicaid 50th percentile, with nine MMA plans and the statewide average ranking above the HPL. No MMA plans fell below the LPL. MMA plan performance varied by over 20 percentage points.

15. Use of Services

Introduction

The Use of Services measure domain encompasses the following measures reported by the Standard and Specialty MMA plans:

- *Ambulatory Care (per 1,000 Member Months)—Outpatient Visits—Total* and *ED Visits—Total*
- *Use of Opioids at High Dosage*
- *Use of Opioids From Multiple Providers—Multiple Prescribers*, *Multiple Pharmacies*, and *Multiple Prescribers and Multiple Pharmacies*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the tables presented in this section. For reference, additional analyses for each measure indicator are displayed in Appendix D.

Measure-Specific Findings

Ambulatory Care (per 1,000 Member Months)

The *Ambulatory* Care *(per 1,000 Member Months)* measure summarizes use of ambulatory care for *Outpatient Visits—Total* and *ED Visits—Total*. In this section, the results for the total age group are presented.

Results

Table 15-1 shows *Outpatient Visits—Total* and *ED Visits—Total* per 1,000 member months.

Table 15-1—Ambulatory Care (per 1,000 Member Months) for Total Age Group

MMA Plan	Member Months	*Outpatient Visits—Total*	*ED Visits—Total**
AMG-M	3,859,062	300.42	63.95
BET-M	1,174,534	267.56	65.20
CCP-M	514,716	282.31	60.48
CHA-S	76,571	411.87	149.04
CMS-S	603,298	485.84	71.19
COV-M	632,463	356.73	62.75
FRE-S	1,584	310.61	53.66
HUM-M	3,893,586	346.95	66.60
MCC-S	597,442	234.71	150.77
MOL-M	3,805,685	320.10	69.29
PHC-S	13,099	495.00	164.97
PRS-M	3,545,001	304.55	73.91
SHP-M	869,716	379.41	53.39

MMA Plan	Member Months	*Outpatient Visits—Total*	*ED Visits—Total**
STW-M	7,325,998	346.46	72.11
SUN-M	5,277,186	282.03	66.71
SUN-S	459,917	297.57	53.45
URA-M	3,017,928	319.44	73.85
RY 2018 Statewide Average	—	**320.24**	**70.09**
RY 2017 Statewide Average	—	**320.89**	**71.22**
RY 2016 Statewide Average	—	**304.82**	**69.06**

** A lower rate may indicate more favorable performance for this measure indicator (i.e., low rates of ED services may indicate better utilization of services).*

For the *Outpatient Visits—Total* and *ED Visits—Total* indicators, the statewide average varied by less than two visits per 1,000 member months from RY 2017 to RY 2018.

Use of Opioids at High Dosage

For enrollees 18 years and older, *Use of Opioids at High Dosage* measures the rate of enrollees using opioids at high dosage per 1,000 enrollees who received prescription opioids for at least 15 days during the measurement year. For this measure, a lower rate indicates better performance. This measure was new for RY 2018; therefore, prior years' results were not available for comparison.

Results

Table 15-2 shows the rate of opioids prescribed at a high dosage. This measure is a first-year measure; therefore, national benchmarks are not available.

Table 15-2—Use of Opioids at High Dosage: Total per 1,000 Enrollees

MMA Plan	Eligible Population	Rate
AMG-M	4,168	114.92
BET-M	1,272	122.64
CCP-M	329	115.50
CHA-S	755	162.91
CMS-S	—	—
COV-M	556	167.27
FRE-S	25	NA
HUM-M	7,878	62.20
MCC-S	2,904	92.98
MOL-M	6,003	59.30
PHC-S	160	0.00
PRS-M	6,786	114.50

MMA Plan	Eligible Population	Rate
SHP-M	1,487	149.29
STW-M	14,509	75.54
SUN-M	6,669	103.91
SUN-S	—	—
URA-M	5,369	64.26
RY 2018 Statewide Average	—	**87.31**
RY 2017 Statewide Average	—	—
RY 2016 Statewide Average	—	—

NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— indicates the MMA plan did not report this measure.

Use of Opioids From Multiple Providers

For enrollees 18 years of age and older, *Use of Opioids From Multiple Providers* measures the rate of enrollees who received opioids from multiple providers per 1,000 enrollees who received prescription opioids for at least 15 days during the measurement year. Three rates are reported: *Multiple Prescribers*, *Multiple Pharmacies*, and *Multiple Prescribers and Multiple Pharmacies*. For this measure, a lower rate indicates better performance. This measure was new for RY 2018; therefore, the prior year's results were not available for comparison.

Results

Table 15-3 shows the rate of enrollees receiving prescriptions for opioids from four or more different prescribers, four or more different pharmacies, and four or more different prescribers and four or more different pharmacies during the measurement year. This measure is a first-year measure; therefore, national benchmarks are not available.

Table 15-3—Use of Opioids From Multiple Providers: Total per 1,000 Enrollees

MMA Plan	Eligible Population	Multiple Prescribers	Multiple Pharmacies	Multiple Prescribers and Multiple Pharmacies
AMG-M	5,248	217.23	54.12	33.35
BET-M	1,568	774.87	774.87	774.87
CCP-M	445	229.21	87.64	65.17
CHA-S	913	779.85	779.85	779.85
CMS-S	—	—	—	—
COV-M	688	177.33	114.83	58.14
FRE-S	29	NA	NA	NA
HUM-M	9,532	202.58	75.33	42.59

MMA Plan	Eligible Population	Multiple Prescribers	Multiple Pharmacies	Multiple Prescribers and Multiple Pharmacies
MCC-S	3,441	768.38	768.38	768.38
MOL-M	7,254	262.34	79.54	51.01
PHC-S	186	139.78	53.76	21.51
PRS-M	8,044	217.18	162.36	79.81
SHP-M	1,727	719.75	719.75	719.75
STW-M	16,973	220.11	73.94	44.60
SUN-M	8,030	215.44	70.36	42.59
SUN-S	—	—	—	—
URA-M	6,498	241.46	39.70	27.70
RY 2018 Statewide Average	—	**280.89**	**154.51**	**124.11**
RY 2017 Statewide Average	—	—	—	—
RY 2016 Statewide Average	—	—	—	—

NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— indicates the MMA plan did not report this measure

16. LTC Plan Results

Introduction

The LTC plans reported the following measures:

- *Care for Older Adults—Advance Care Planning—Total*, *Medication Review—Total*, and *Functional Status Assessment—Total*
- *Call Answer Timeliness*
- *Required Record Documentation—701B Assessment*, *Plan of Care—Enrollee Participation*, *Plan of Care—Primary Care Physician Notification*, *Freedom of Choice Form*, and *Plan of Care/LTC Service Authorizations*
- *Face-to-Face Encounters*
- *Case Manager Training*
- *Timeliness of Service (TOS)*

Please see the "How to Get the Most From This Report" section for guidance on interpreting the figures presented in this section. For reference, additional analyses for each measure indicator are displayed in Appendix E.

Summary of Findings

Table 9-1 presents the statewide average results for the measure indicators for the LTC plans. The table lists the RY 2018 statewide average and performance levels, a comparison of the RY 2017 to the RY 2018 statewide average for each measure indicator with trend analysis results, and a summary of the LTC plans with rates demonstrating statistically significant changes from RY 2017 to RY 2018.

Table 9-1—RY 2018 Statewide Performance Levels and Trend Results for Long-Term Care Plans

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of LTC Plans With Statistically Significant Improvement in RY 2018	Number of LTC Plans With Statistically Significant Decline in RY 2018
Care for Older Adults				
Advance Care Planning—Total	94.70%	**+10.71**$^{+}$	6	0
Medication Review—Total	79.40%	**+47.55**$^{+}$	3	0
Functional Status Assessment—Total	93.21%	**+0.83**$^{+}$	3	1
Call Answer Timeliness[3]				
Call Answer Timeliness	93.86%	**+5.99**$^{+}$	4	2

Measure	RY 2018 Statewide Average and Performance Level[1]	RY 2017 Statewide Average–RY 2018 Statewide Average Comparison[2]	Number of LTC Plans With Statistically Significant Improvement in RY 2018	Number of LTC Plans With Statistically Significant Decline in RY 2018
Required Record Documentation				
701B Assessment	96.12%	**+6.41⁺**	2	0
Care Plan—Enrollee Participation	74.71%	**+1.00⁺**	2	2
Care Plan—Primary Care Physician Notification	64.18%	**+7.67⁺**	5	0
Freedom of Choice Form	82.06%	**-2.33⁺⁺**	3	2
*Plan of Care/LTC Service Authorizations**	1.08%	**+0.45⁺⁺**	1	1
Face-to-Face Encounters				
Face-to-Face Encounters	84.37%	**+7.96⁺**	2	3
Case Manager Training				
Case Manager Training	96.88%	-0.13	2	1
Timeliness of Services				
Timeliness of Services	81.05%	**+9.62⁺**	3	2

[1] 2018 performance levels were based on comparisons of the RY 2018 statewide average measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks. 2018 performance levels represent the following percentile comparisons:

≤25th	≥25th and ≤49th	≥50th and ≤74th	≥75th and ≤89th	≥90th

[2] RY 2017 statewide average to RY 2018 statewide average comparisons were based on a Chi-square test of statistical significance with a p-value <0.01 due to large denominators.

[3] Current benchmarks are not available for this measure, as it was retired for RY 2017. Therefore, 2018 performance levels were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for RY 2015 (the most recent year available).

** For this indicator, a lower rate indicates better performance.*

Green Shading⁺ *Indicates that the RY 2018 statewide average demonstrated a statistically significant improvement from the RY 2017 statewide average.*

Red Shading⁺⁺ *Indicates that the RY 2018 statewide average demonstrated a statistically significant decline from the RY 2017 statewide average.*

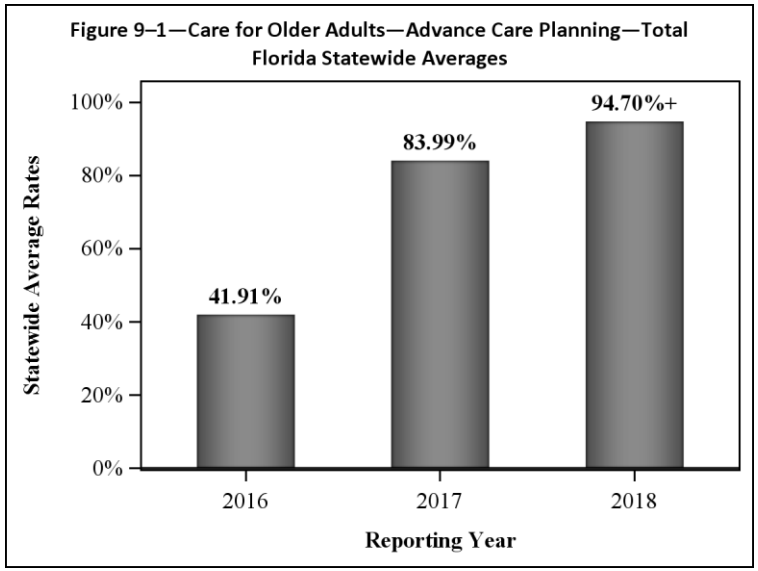
Table 9-1 shows that for the LTC plans, nine of 12 statewide average rates (75 percent) demonstrated significant increases from RY 2017 to RY 2018. Additionally, the statewide average rate for *Call Answer Timeliness*, the only measure with a 2018 performance target established by AHCA, ranked above the 90th percentile. Of note, the statewide average rate for *Care for Older Adults—Medication Review—Total* demonstrated a significant increase of over 47 percentage points from RY 2017 to RY 2018.

Conversely, two of 12 statewide average rates (approximately 17 percent) demonstrated significant declines from RY 2017 to RY 2018.

Measure-Specific Findings

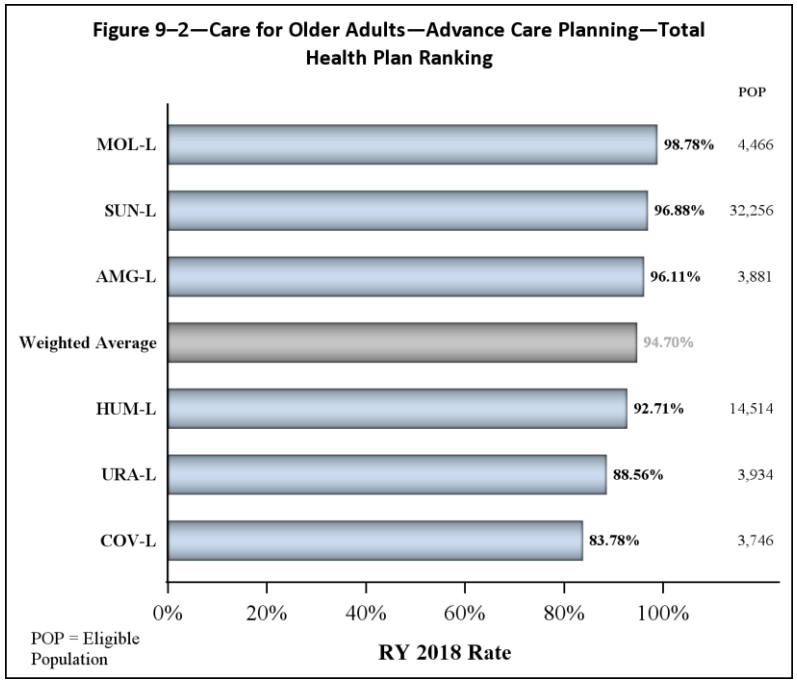
Care for Older Adults—Advance Care Planning—Total

Care for Older Adults—Advance Care Planning—Total measures the percentage of adults 18 years and older who had evidence of advance care planning during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

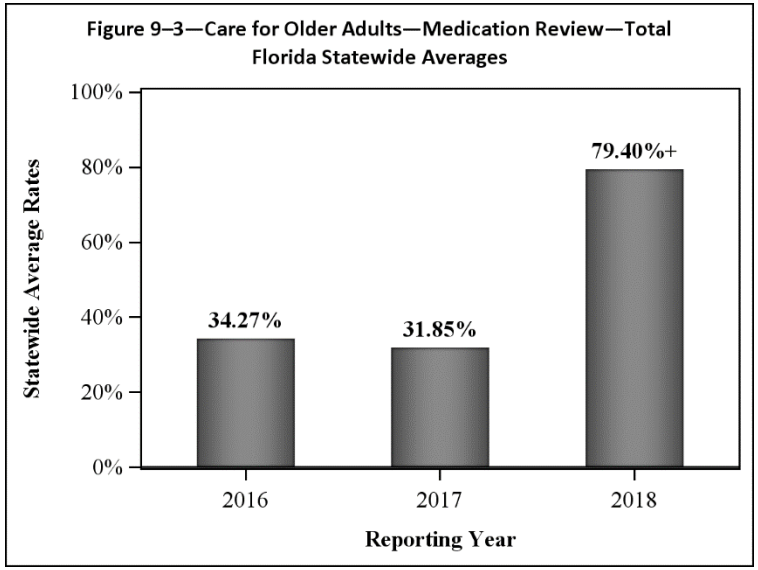


Although this measure was reported as hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. LTC plan performance varied by 15 percentage points.

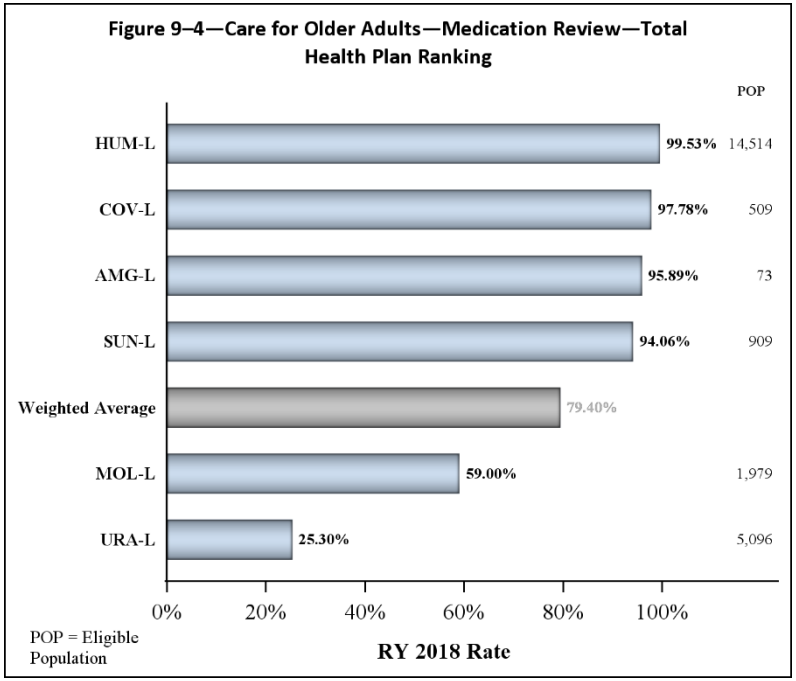
Care for Older Adults—Medication Review—Total

Care for Older Adults—Medication Review—Total measures the percentage of adults 18 years and older who received at least one medication review, including the presence of a medication list, or who received transitional care management services during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

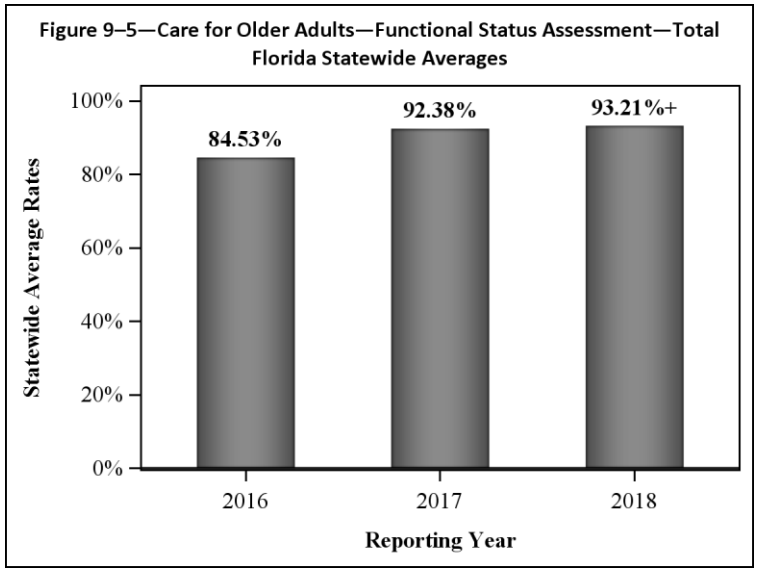


Although this measure was reported as hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. LTC plan performance varied by nearly 75 percentage points.

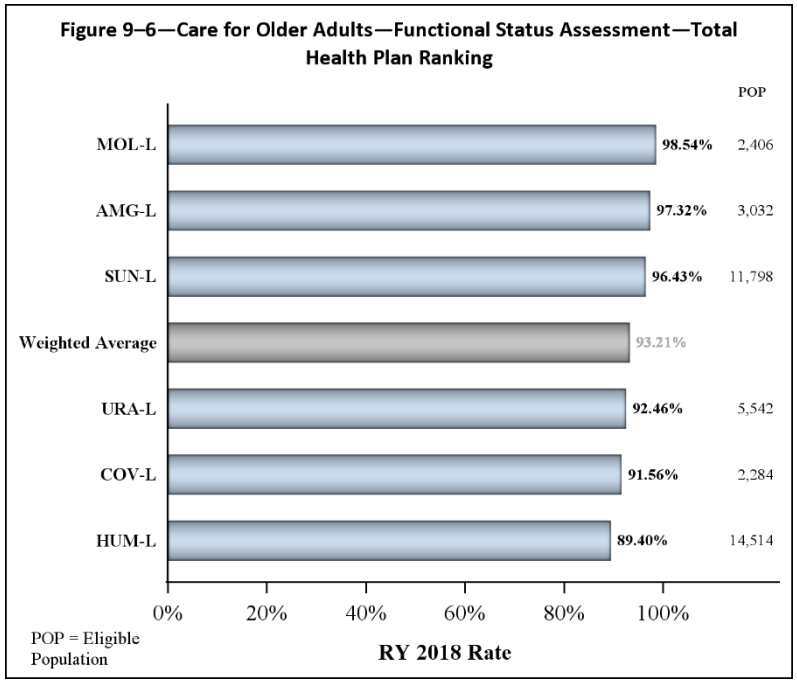
Care for Older Adults—Functional Status Assessment—Total

Care for Older Adults—Functional Status Assessment—Total measures the percentage of adults 18 years and older who received at least one functional status assessment during the measurement year.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

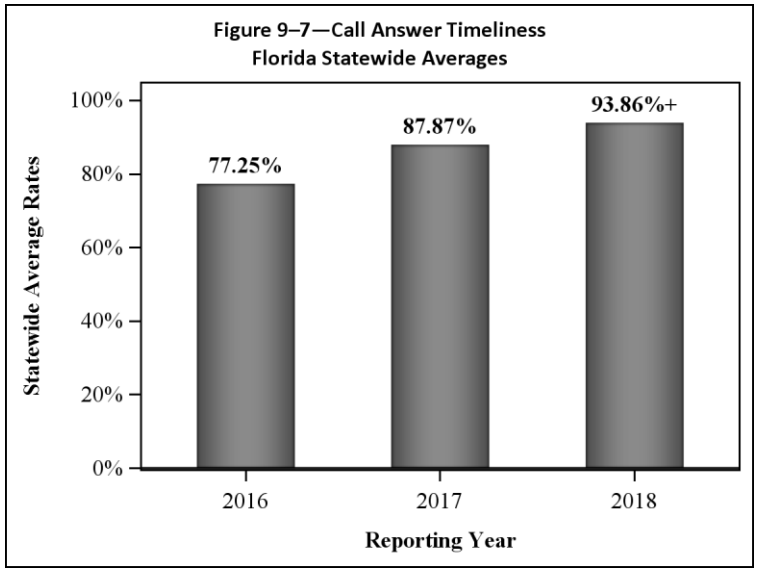


Although this measure was reported as hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. LTC plan performance varied by nearly 10 percentage points.

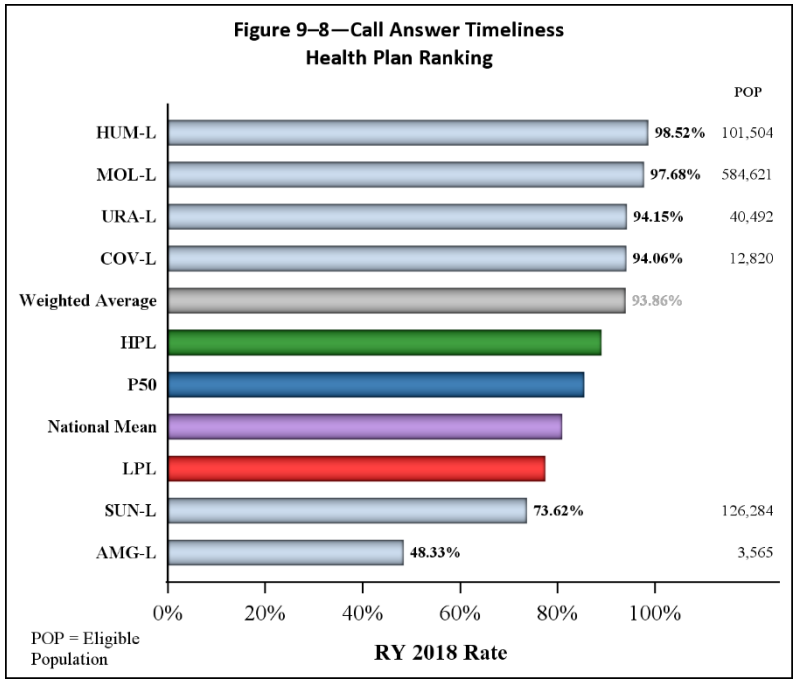
Call Answer Timeliness—Total

Call Answer Timeliness assesses the percentage of calls received during the measurement year by the MMA plans' enrollee services call centers (during operating hours) that were answered by a live voice within 30 seconds.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



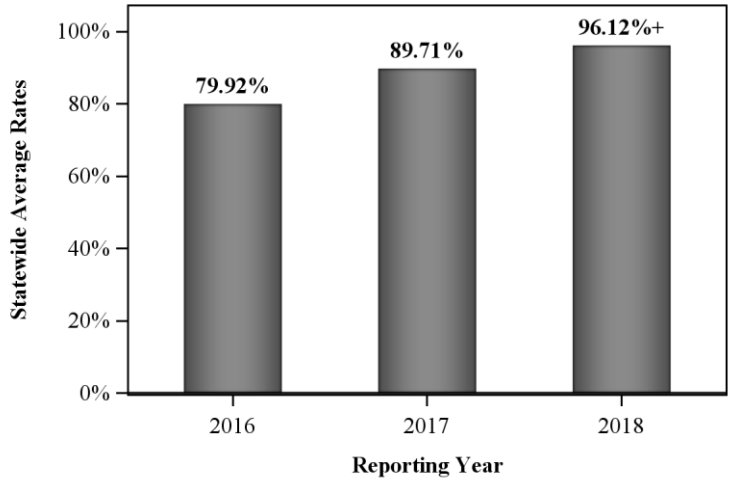
2018 Quality Compass percentiles for this measure were not available; therefore, the rate for this measure indicator were compared to Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015 (the most recent year available).

Four LTC plans and the statewide average ranked above the national Medicaid 50th percentile and the HPL. One LTC plan fell below the LPL. LTC plan performance varied by over 50 percentage points.

Required Record Documentation—701B Assessment

Required Record Documentation—701B Assessment measures the percentage of enrollees whose record contains documentation of an annual 701B assessment that was completed within the measurement year at the initial visit (for new enrollees) or at the annual reassessment visit (for established enrollees). If a 701B form is present in the record but was conducted outside of the time requirement, the record is noncompliant.

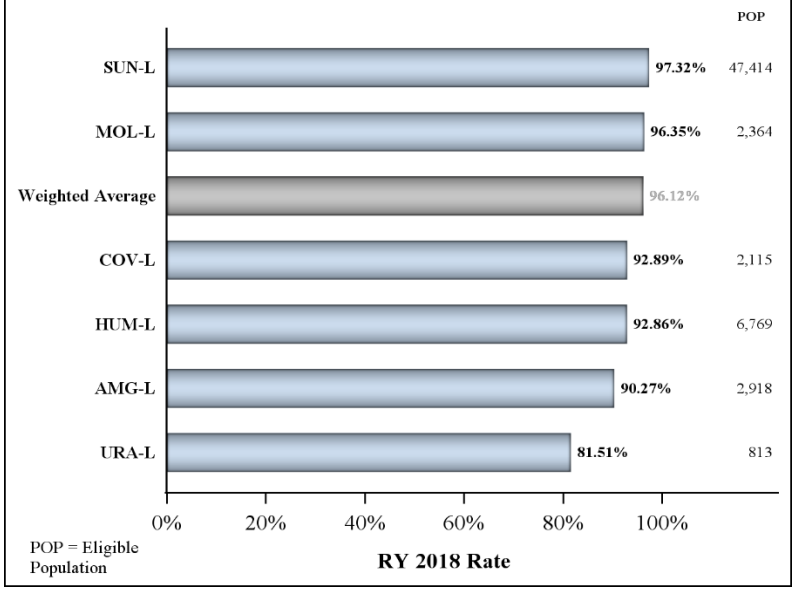
Figure 9–9—Required Record Documentation—701B Assessment
Florida Statewide Averages



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

Figure 9–10—Required Record Documentation—701B Assessment
Health Plan Ranking

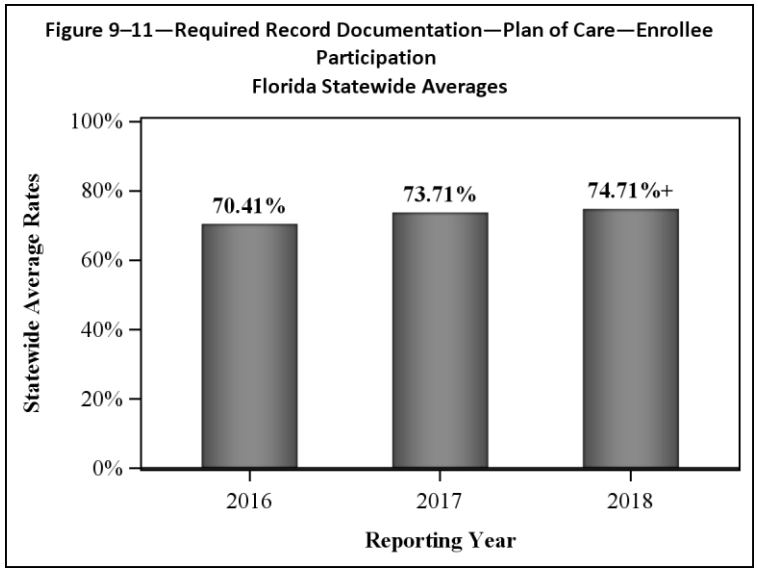


Although this measure was reported as hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

Although AHCA did not set a performance target for this measure for 2018, these are required documents. Therefore, the expectation is that LTC plans include these documents in all enrollees' records. LTC plan performance varied by over 15 percentage points.

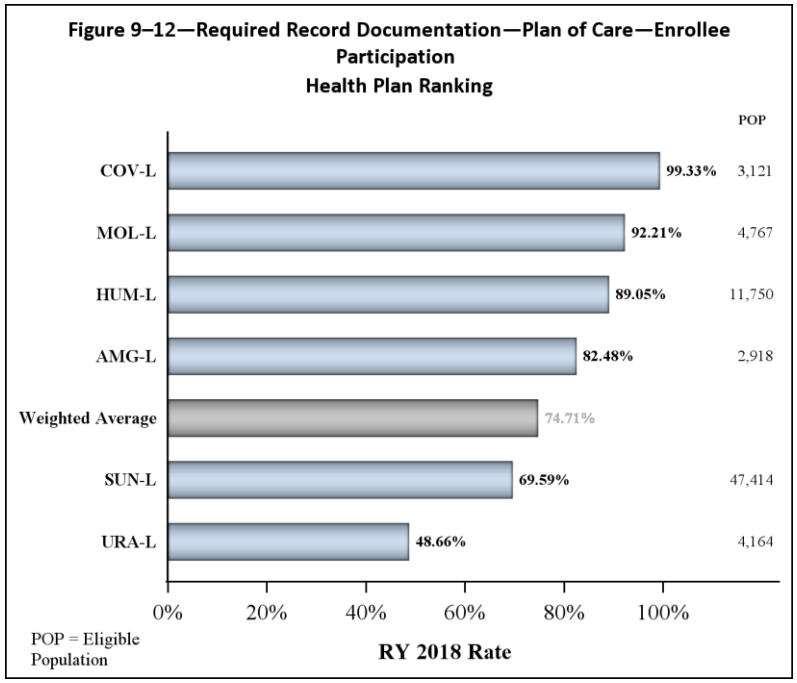
Required Record Documentation—Plan of Care—Enrollee Participation

Required Record Documentation—Plan of Care—Enrollee Participation measures the percentage of enrollees whose record contains a plan of care signed by the enrollee or the enrollee's representative.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.

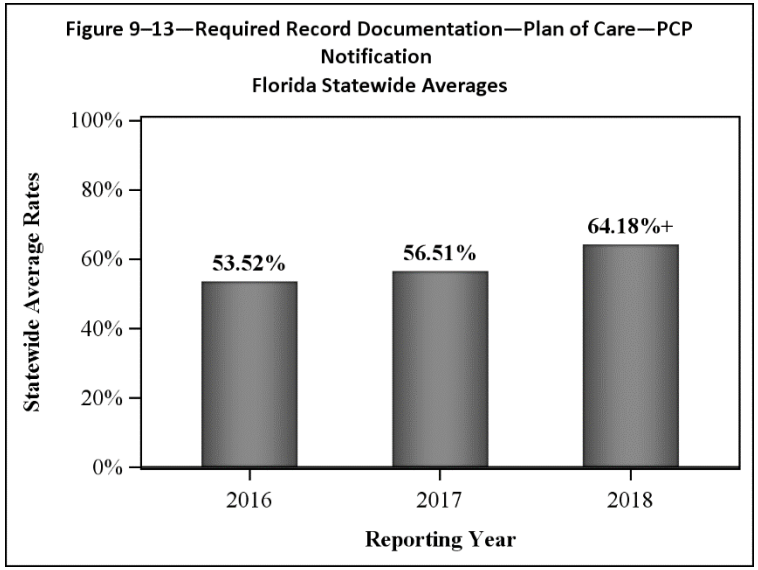


Although this measure was reported as hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

Although AHCA did not set a performance target for this measure for 2018, these are required documents. Therefore, the expectation is that LTC plans include these documents in all enrollees' records. LTC plan performance varied by over 50 percentage points.

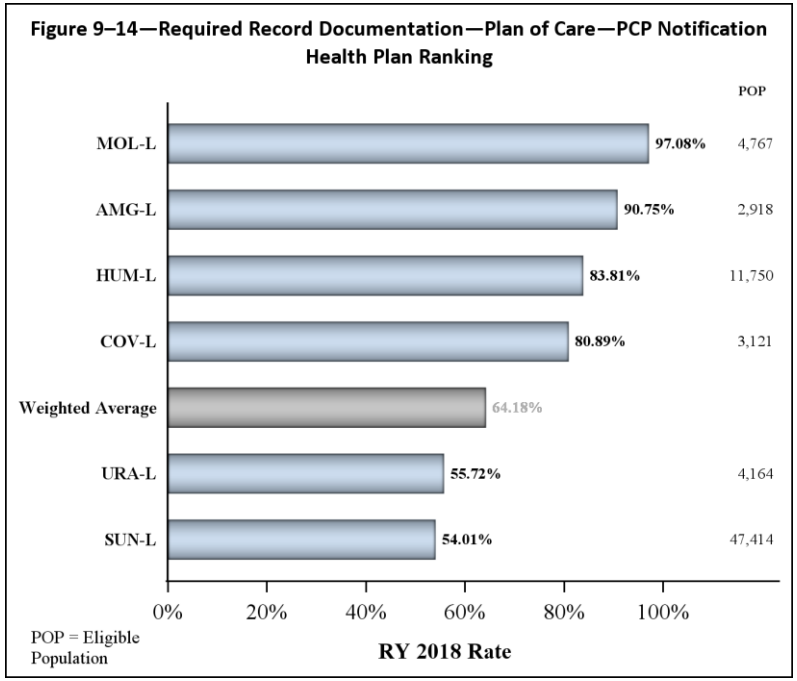
Required Record Documentation—Plan of Care—PCP Notification

Required Record Documentation—Plan of Care—PCP Notification measures the percentage of enrollees whose record indicates that the plan of care was sent to the PCP within 10 business days of development for new enrollees or within 10 business days of the annual reassessment for established enrollees.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



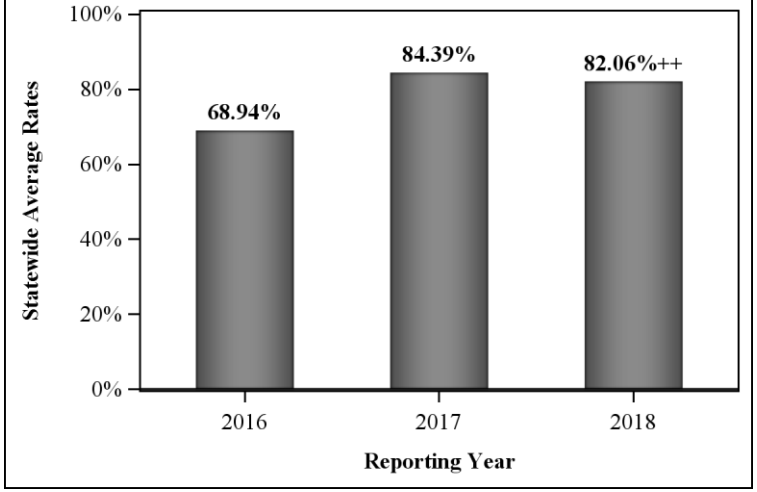
Although this measure was reported as hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

Although AHCA did not set a performance target for this measure for 2018, these are required documents. Therefore, the expectation is that LTC plans include these documents in all enrollees' records. LTC plan performance varied by nearly 45 percentage points.

Required Record Documentation—Freedom of Choice Form

Required Record Documentation—Freedom of Choice Form measures the percentage of enrollees whose record contains a completed Freedom of Choice Form signed by the enrollee or the enrollee's representative.

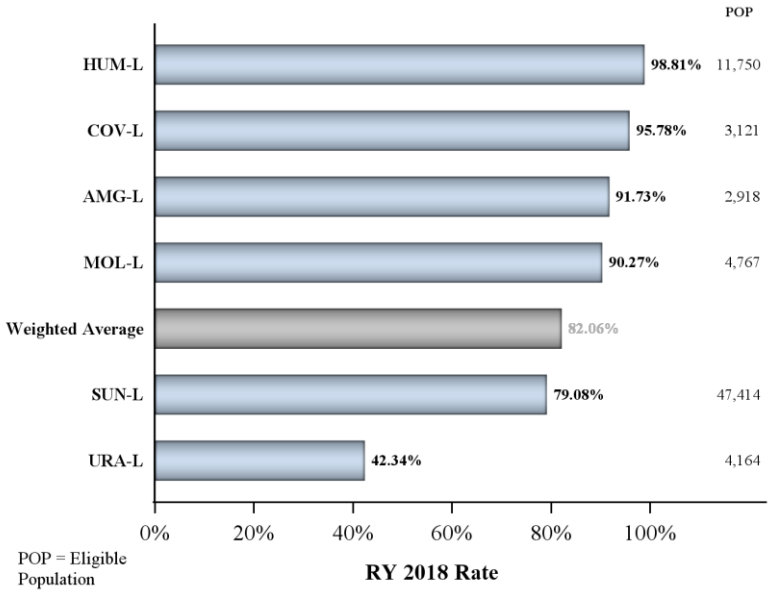
Figure 9–15—Required Record Documentation—Freedom of Choice Form
Florida Statewide Averages



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly declined from RY 2017.

Figure 9–16—Required Record Documentation—Freedom of Choice Form
Health Plan Ranking



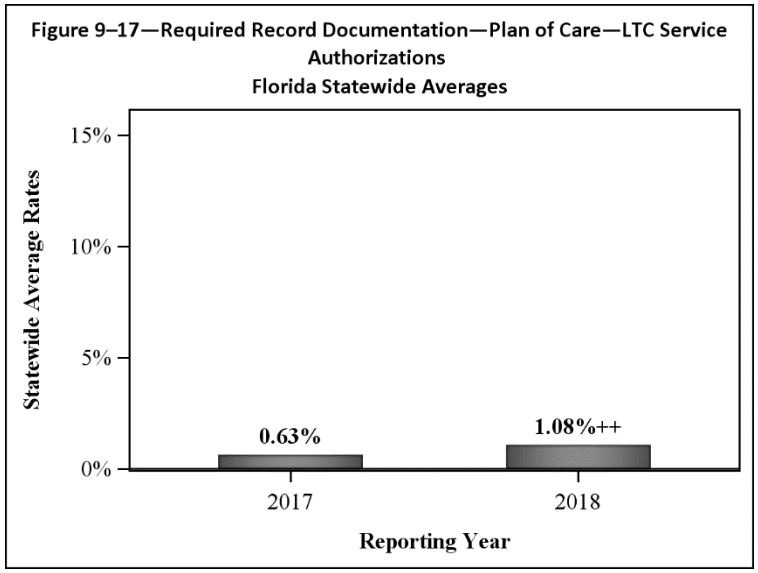
Although this measure was reported as hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

Although AHCA did not set a performance target for this measure for 2018, these are required documents. Therefore, the expectation is that LTC plans include these documents in all enrollees' records. LTC plan performance varied by over 55 percentage points.

Required Record Documentation—Plan of Care—LTC Service Authorizations

Required Record Documentation—Plan of Care—LTC Service Authorizations measures the percentage of enrollees whose record contains a plan of care that includes an LTC service authorization for maintenance therapies for time periods that are shorter than the end date of the plan of care and does not include subsequent service authorizations for the same service. For this indicator, a lower rate indicates better performance.

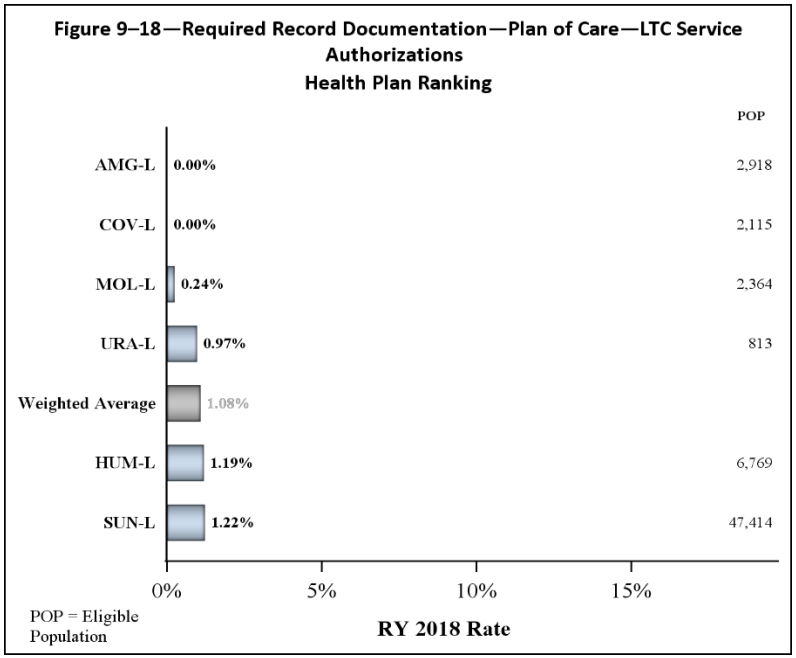
Figure 9–17—Required Record Documentation—Plan of Care—LTC Service Authorizations
Florida Statewide Averages



Rates with two crosses (++) indicate a significant decline in performance from the previous year.

The RY 2018 statewide average rate significantly increased from RY 2017, representing a decline in performance as a lower rate indicates better performance for this measure.

Figure 9–18—Required Record Documentation—Plan of Care—LTC Service Authorizations
Health Plan Ranking

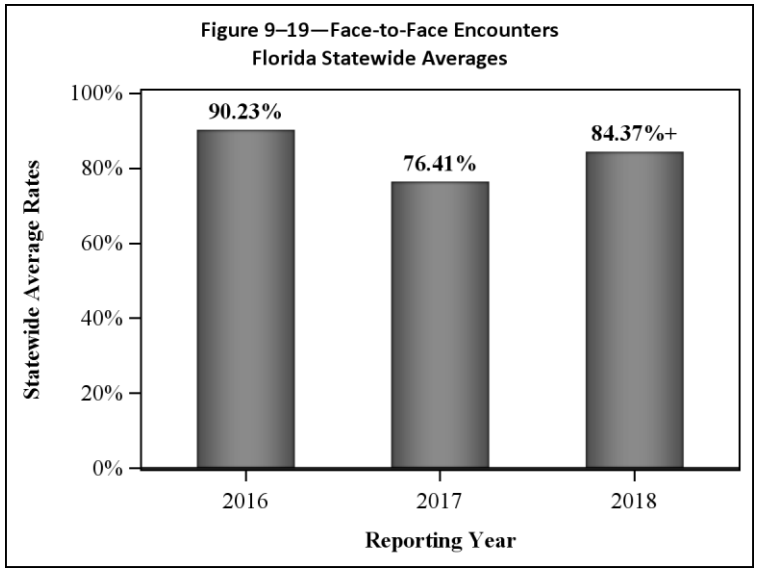


Although this measure was reported as hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. LTC plan performance varied by over 1 percentage point.

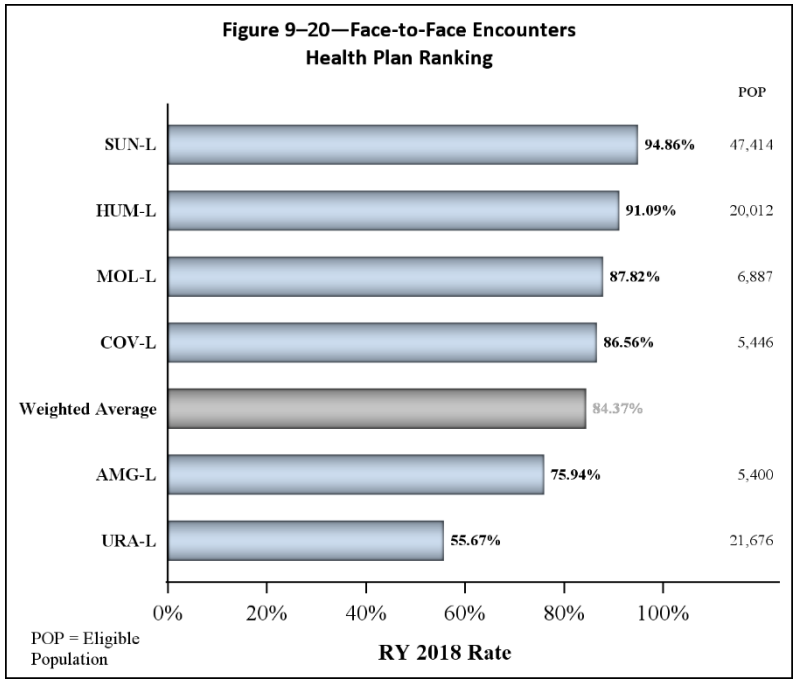
Face-to-Face Encounters

Face-to-Face Encounters measures the percentage of enrollees who had a face-to-face encounter with a care/case manager every three months.



Rates with one cross (+) indicate a significant improvement in performance from the previous year.

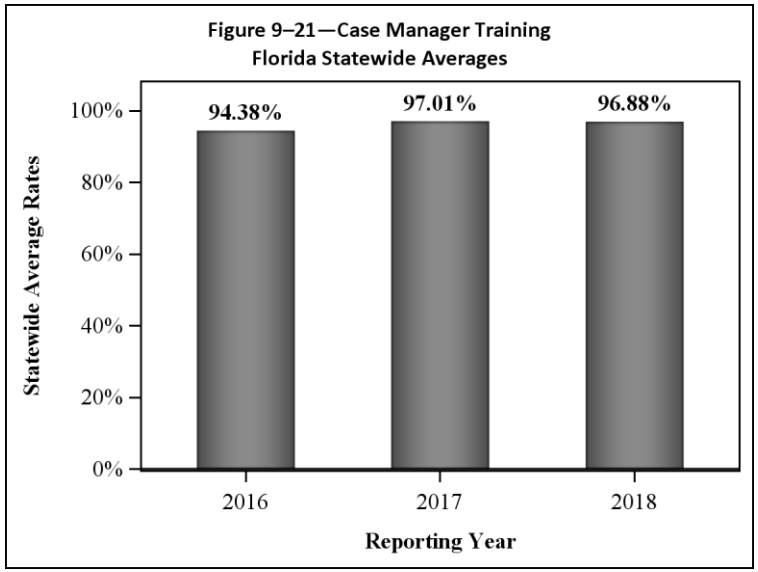
The RY 2018 statewide average rate significantly improved from RY 2017.



AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. LTC plan performance varied by nearly 40 percentage points.

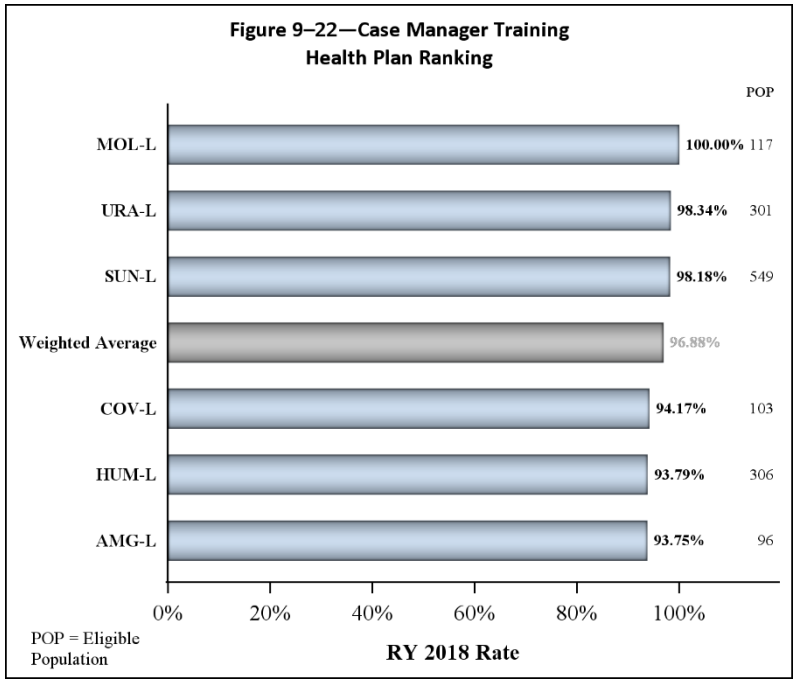
Case Manager Training

Case Manager Training measures the percentage of the LTC plans' case managers who received training on the mandate to report abuse, neglect, and exploitation.



Due to issues associated with the plan-level eligible population values for this measure, the 2016 statewide average was weighted by select plans' denominators rather than by the eligible populations; therefore, caution should be exercised when trending the statewide average for 2016 to 2017 and 2018.

The RY 2018 statewide average rate did not demonstrate a significant change from 2017 to 2018.

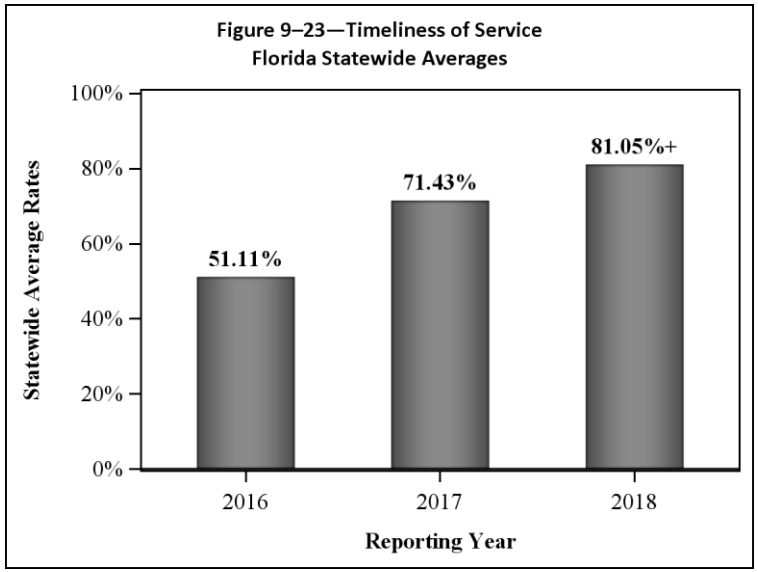


Although this measure was reported hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. LTC plan performance varied by over 5 percentage points.

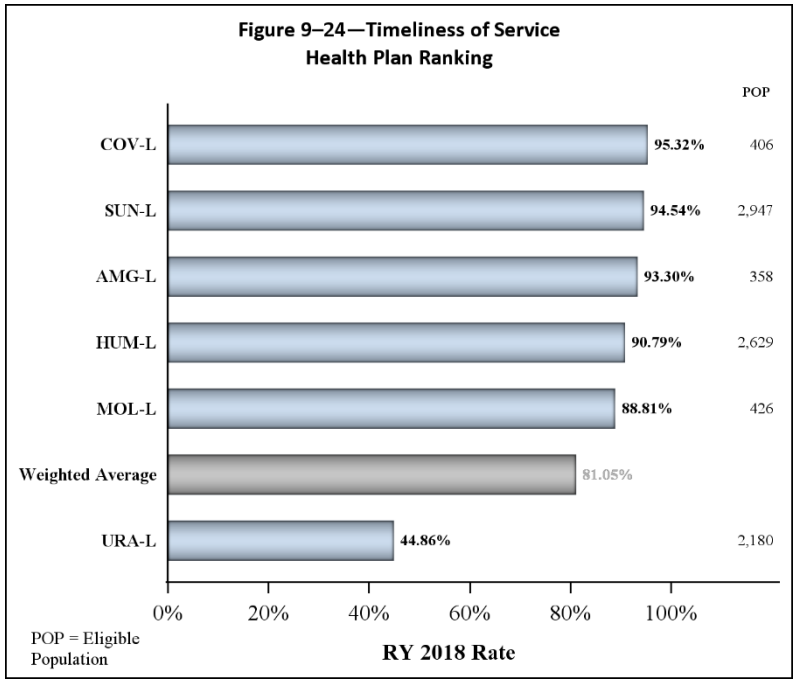
Timeliness of Service

Timeliness of Service measures the percentage of new enrollees who received services no later than 14 days after the development of a plan of care.



Due to issues associated with the plan-level eligible population values for this measure, the 2016 statewide average was weighted by select plans' denominators rather than by the eligible populations; therefore, caution should be exercised when trending the statewide average for 2016 to 2017 and 2018.
Rates with one cross (+) indicate a significant improvement in performance from the previous year.

The RY 2018 statewide average rate significantly improved from RY 2017.



Although this measure was reported hybrid by the LTC plan, the percentage of MRR data could not be determined due to limitations in the measure collection tool.

AHCA did not set a performance target for this measure for 2018; therefore, the rates in the chart above are presented for information only. LTC plan performance varied by over 50 percentage points.

Appendix A. Glossary

Glossary

Table A-1 below provides definitions of terms and acronyms used throughout this report.

Table A-1—Definition of Terms

Term	Description
Administrative Data	Any automated data within a plan's data system (e.g., claims/encounter data, enrollee data, provider data, hospital billing data, pharmacy data, and laboratory data).
Administrative Method	A method that requires plans to identify the eligible population (i.e., the denominator) using administrative data. In addition, the numerator(s), or services provided to the enrollees in the eligible population are solely derived from administrative data. Medical records cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator. The administrative method does not allow sampling. The administrative method is cost-efficient but can produce lower rates due to incomplete data submission by capitated providers.
Audit Means and Percentiles	NCQA's published percentiles for each HEDIS measure for the Medicaid product line, which can be used to compare plan performance.
Audit Result	The HEDIS auditor's final determination, based on audit findings, of the appropriateness of the MMA plan to publicly report its HEDIS measure rates. Each measure indicator rate included in the HEDIS audit receives an audit result of *Reportable (R), Small Denominator (NA), Biased Rate (BR), No Benefit (NB), Not Required (NQ), Not Reported (NR),* and *Unaudited (UN).*
Capitation	A method of payment for providers. Under a capitated payment arrangement, providers are reimbursed on a per enrollee/per month basis. The provider receives payment each month prospectively, whether or not the enrollee receives services. Therefore, because payment is not based on individual encounter submissions, little incentive exists for providers to submit individual encounters.
Claims-Based Denominator	A plan's eligible population for a measure that is obtained from claims data. For a claims-based denominator, plans must identify their eligible population and draw their sample no earlier than January of the year following the measurement year. This ensures that most claims incurred through December 31 of the measurement year are captured in their systems.

Term	Description
CMS	The Centers for Medicare & Medicaid Services (CMS) provides health insurance to individuals through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). In addition, CMS regulates laboratory testing through Clinical Laboratory Improvement Amendments (CLIA), develops coverage policies, and initiates quality of care improvement activities. CMS also maintains oversight of nursing homes and continuing care providers. This includes home health agencies, intermediate care facilities for individuals with intellectual/developmental disabilities, and hospitals.
Continuous Enrollment Requirement	The minimum amount of time an enrollee must be enrolled in a managed care plan to be eligible for inclusion in a measure, ensuring that the managed care plan has a sufficient amount of time to be held accountable for providing services to that enrollee.
CPT	Current Procedural Terminology (CPT®) is a listing of billing codes generated by the American Medical Association to report the provision of medical services and procedures. CPT is a registered trademark of the American Medical Association.
Data Completeness	The degree to which occurring services/diagnoses appear in a plan's administrative data systems.
Denominator	The number of enrollees who meet all criteria specified in the measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.
Electronic Data	Data that are maintained in a computer environment versus a paper environment.
Encounter Data	Service data received from a capitated provider under managed care. Although a plan does not reimburse a capitated provider for each encounter, submission of encounter data to a plan by the provider allows the plan to collect the data and monitor the services provided to its enrollees.
Exclusions	The conditions outlined in measure specifications that describe when an enrollee should not be included in the denominator.
FFS	Fee-for-service (FFS) is a reimbursement mechanism under which the provider is paid for services billed.
Final Audit Report (FAR)	After a plan completes any corrective actions, the auditor completes a written report documenting all final findings and results of an NCQA HEDIS Compliance Audit. The final audit report includes the summary report, IS capabilities assessment, medical record review validation findings, measure designations, and audit opinion (final audit statement).
HCPCS	Healthcare Common Procedure Coding System (HCPCS)—a standardized alphanumeric coding system that maps to certain CPT codes (See also CPT).
HEDIS	Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by plans.

Term	Description
HEDIS Measure Determination Standards (HD)	The standards that auditors use during the audit process to assess a plan's adherence to HEDIS measure specifications.
HEDIS Repository	The data warehouse where all data used for HEDIS reporting are stored.
HEDIS Warehouse	See HEDIS repository.
HSAG	Health Services Advisory Group, Inc., AHCA's contractor for the federally mandated external quality review of Florida's Medicaid managed care program.
Hybrid Measures	Measures that can be reported using the hybrid method (i.e., allowance of data retrieved from the medical record to be included in the reported rate calculations) (See also Hybrid Method).
Hybrid Method	A method that requires plans to identify the eligible population using administrative data and then extract a systematic sample from the eligible population, which becomes the denominator (as long as the cases met the denominator criteria). Administrative data are then used to identify services provided to those sampled enrollees. Medical records must be reviewed for those enrollees who do not have evidence of a service being provided using administrative data. The hybrid method generally produces higher results but is considerably more labor-intensive. For example, a plan has 10,000 enrollees who qualify for the *Adolescent Well-Care Visits* measure and the plan chooses to perform the hybrid method. After randomly selecting 411 eligible enrollees using administrative data, the plan finds that 161 had evidence of a well-care visit. The plan then obtains and reviews medical records for the 250 enrollees who do not have evidence of a well-care visit using administrative data. Of those 250 enrollees, 54 are found to have a well-care visit recorded in the medical record. The final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52 percent.
ICD-10-CM	The acronym for the International Classification of Diseases, 10th Revision, Clinical Modification is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with hospital care in the United States.
IDSS	Interactive Data Submission System—a tool used to submit performance measure data to NCQA.
Inpatient Data	Data derived from an inpatient hospital stay.
IS	An automated information system (IS) used for collecting, processing, and transmitting data.
IT	Information technology (IT) is the technology used to create, store, exchange, and use information in its various forms.
Key Data Elements	The data elements that must be captured to report performance measures.
Logic Checks	Evaluations of programming logic to determine its accuracy.

Term	Description
LOINC	Logical Observation Identifiers Names and Codes. This refers to a dataset of universal identifiers for laboratory and other clinical observations to facilitate exchange and storage of clinical results.
Manual Data Collection	Collection of data through a paper process rather than an automated process.
Mapping Codes	The process of translating a managed care plan's propriety or nonstandard billing codes to industry standard codes specified in HEDIS measures. Mapping documentation should include a crosswalk of relevant codes, descriptions, and clinical information, as well as the policies and procedures for implementing the codes.
Material Bias	For measures reported as a rate, any error that causes a ± 5 percent difference in the reported rate.
Medicaid Percentiles	NCQA's published percentiles, known as Quality Compass, for each HEDIS measure for the Medicaid product line, which can be used to compare plan performance.
Medical Record Review Validation	The process that auditors follow to verify that a plan's medical record abstraction meets industry standards and that abstracted data are accurate.
Modifier Codes	Two- or five-digit extensions added to CPT codes to provide additional information about services/ procedures.
NCQA	The National Committee for Quality Assurance (NCQA), a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed healthcare delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the healthcare provided within the managed care industry.
NDC	National drug codes (NDC) used for billing pharmacy services.
Numerator	The number of enrollees from the denominator who received all the services as specified in the measure.
Over-Read Process	The process of re-reviewing a sample of medical records by a different abstractor to assess the degree of agreement between two different abstractors and ensure the accuracy of abstracted data. A plan should conduct an over-read process as part of its medical record review process, and auditors should overread a sample of a plan's medical records as part of the audit process.
Pharmacy Data	Data derived from the provision of pharmacy services.
Practitioner Data	Electronic files containing information about practitioners, such as the type of physician, specialty, reimbursement arrangement, and office location.
Primary Source Verification	The practice of reviewing the processes and procedures to input, transmit, and track data from the originating source to the HEDIS repository to verify that the originating information matches the output information for HEDIS reporting.
Proprietary Codes	Unique billing codes developed by a plan that have to be mapped to industry standard codes for HEDIS reporting.

Term	Description
Quality Compass	NCQA's published percentiles for each HEDIS measure for the Medicaid product line, which can be used to compare plan performance.
Record of Administration, Data Management, and Processes (Roadmap)	The Roadmap, completed by each plan undergoing the NCQA HEDIS Compliance Audit process, provides information to auditors regarding the plan's systems for collecting and processing data for HEDIS reporting. Auditors review the Roadmap prior to the scheduled on-site visit to gather preliminary information for planning/targeting on-site visit assessment activities; determine the core set of measures to be reviewed; determine which hybrid measures will be included in medical record validation; request core measures' source code, as needed; identify areas that require additional clarification during the on-site visit; and determine whether the core set of measures needs to be expanded. Previously known as the Baseline Assessment Tool (BAT).
Retroactive Enrollment	The effective date of an enrollee's enrollment in a plan that occurs prior to the date the plan is initially notified of that enrollee's enrollment. Medicaid enrollees who are retroactively enrolled in a plan must be excluded from a HEDIS measure denominator if the time period from the date of enrollment to the date of notification exceeds the measure's allowable gap specifications.
Revenue Codes	Cost codes for facilities to bill by category: services, procedures, supplies, and materials.
Sample Frame	In the hybrid method, the eligible population meeting all criteria specified in the measure from which the systematic sample is drawn.
Software Vendor With NCQA-Certified Measures	A third party whose source code has been certified by NCQA and that contracts with a plan to write source code for HEDIS measures. All of the vendor's programmed HEDIS measures must be submitted to NCQA for automated testing of program logic, and all of the measures must receive a *Pass* or *Pass With Qualifications* designation.
Source Code	The written computer programming logic for determining the eligible population, the denominators, and the numerators for calculating the rate for each measure.
Standard Codes	Industry standard billing codes such as ICD-10-CM, CPT, DRG, Revenue, and UB-92 codes used for billing inpatient and outpatient healthcare services.
UB-92 Claims	A type of claim form used to bill hospital-based inpatient, outpatient, emergency room, and clinic drugs, supplies, and/or services. UB-92 codes are primarily Type of Bill and Revenue codes.
Vendor	Any third party who contracts with a managed care plan to perform services. The most common delegated services are pharmacy, vision care, laboratory, claims processing, HEDIS software, and provider credentialing services.

Appendix B. Description of MMA Plan Validation Activities

MMA Description of SFY 2017–2018 Validation Activities

MMA Plans

AHCA contracted with HSAG to audit independently the performance measures, data submission tools, and FARs produced for each Standard and Specialty MMA plan during SFY 2017–2018. The intent of the independent audits was to determine the extent to which these measures reported to AHCA were calculated according to AHCA's specifications. HSAG conducted its performance measure validation (PMV) activity for the MMA plans during SFY 2017–2018. To avoid any redundant auditing process, HSAG evaluated the NCQA HEDIS Compliance Audit process in light of the steps described in the CMS protocol and focused on using three primary sources to conduct its PMV audits for MMA plans: The Record of Administration, Data Management, and Processes (Roadmap); the final audit results; and the Final Audit Report (FAR). These data sources are important documents used/generated during a typical NCQA HEDIS Compliance Audit.[B-1]

presents critical elements and approaches that HSAG used to conduct the PMV activities for MMA plans.

Table B-3—Key PMV Steps Performed by HSAG

PMV Step	Associated Activities Performed by HSAG
Pre-On-Site Visit Call/Meeting	HSAG verified that the licensed organizations (LOs) addressed key topics such as timelines and on-site review dates.
HEDIS Roadmap Review	HSAG examined the completeness of the Roadmap and looked for evidence in the FARs that the LOs completed a thorough review of all Roadmap components.
Software Vendor	If an MMA plan used a software vendor to produce measure rates, HSAG assessed whether or not the MMA plan contracted with a vendor who calculates and produces rates and if this software vendor achieved full measure certification status by NCQA for the reported HEDIS measure. Where applicable, the NCQA Measure Certification letter was reviewed to ensure that each measure was under the scope of certification. Otherwise, HSAG examined whether source code review was conducted by the LOs (see next step below).

[B-1] During an NCQA HEDIS Compliance Audit, the licensed organization (LO) evaluates the MMA plan's data management and reporting capabilities by reviewing the HEDIS Record of Administration, Data Management, and Processes (Roadmap); conducting interviews with key MMA plan staff members; and generating data queries to review data in the output files. The results of the audits were presented in a FAR. The Roadmap, completed by the MMA plan, contains detailed information on data systems and processes used in calculating the performance measures. The final audit results are the final determinations of validity made by the auditor for each performance measure. The FAR includes information on the MMA plans' information systems capabilities, findings for each measure, medical record review (MRR) validation results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement.

PMV Step	Associated Activities Performed by HSAG
Source Code Review	HSAG ensured that if a software vendor with certified HEDIS measures was not used, the LOs reviewed the MMA plan's programming language for both HEDIS and non-HEDIS measures. Source code review was used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (ensuring that rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).
Primary Source Verification	HSAG verified that the LOs conducted appropriate checks to ensure that records used for HEDIS reporting match with the primary data source. This step occurs to determine the validity of the source data used to generate the measure rates.
Supplemental Data Validation	If the MMA plan used any supplemental data for reporting, the LO was to validate the supplemental data according to NCQA's guidelines. HSAG verified whether or not the LO was following the NCQA-required approach while validating the supplemental database.
Convenience Sample Validation	HSAG verified that, as part of the medical record review validation (MRRV) process, the LOs identified whether the MMA plans were required to prepare a convenience sample and, if not, whether specific reasons were documented.
MRRV	HSAG examined whether the LOs performed a re-review of a random sample of medical records based on NCQA MRRV protocol to ensure the reliability and validity of the data collected.
Health Plan Quality Indicator Data File Review	The MMA plans are required to submit a health plan quality indicator data file for the submission of audited rates to AHCA. The file should comply with the AHCA-specified reporting format and contain the denominator, numerator, and reported rate for each performance measure. HSAG evaluated whether there was any documentation in the FAR to demonstrate that the LOs performed a review of the health plan quality indicator data file.

Based on the FARs, HSAG identified whether the LOs completed each key element. NCQA does not require that the FAR address all key elements listed in Table B-1. However, the elements represent activities that auditors perform as part of the audit. The presence or absence of these elements within the FARs would not affect HSAG's review because all MMA plans used LOs to perform the NCQA HEDIS Compliance Audits.

In general, the LOs that were contracted by all MMA plans included sufficient details in the FARs to describe specific validation components during their NCQA HEDIS Compliance Audit. With a few exceptions, required activities such as the pre-on-site visit meeting, Roadmap review, source code review, and MRRV were clearly mentioned in the FARs. There were some variations in how the LOs documented their reviews of AHCA Quality Indicator files in the report.

Rate Validity

To evaluate an MMA plan's capabilities for accurate HEDIS reporting, HSAG reviewed each FAR submitted by the MMA plan to confirm/evaluate the LO's assessment of information systems (IS) capabilities, specifically focusing on aspects of the MMA plan's system that could affect the HEDIS Medicaid reporting set.[B-2]

NCQA's IS standards detail the minimum requirements for a plan's IS, as well as criteria that must be met for any manual processes used to report HEDIS information. In accordance with the 2018 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures*, *Volume 5*, the LOs evaluated IS compliance with NCQA's IS standards. When a particular IS standard was not met, the LOs determined the impact on HEDIS reporting capabilities, specifically identifying any measure that could be impacted. An MMA plan may not be fully compliant with many of the IS standards yet fully able to report the selected measures.

Audit Designations

Each measure reviewed by the MMA plans' auditors received an audit designation result based on the seven NCQA categories listed below. Table B-5 shows NCQA's measure-level audit designation categories.[B-3]

Table B-4—Measure-Level Audit Designation Categories—NCQA

Audit Designation Result	Definition
R	*Reportable.* The organization followed the specifications and produced a reportable rate or result for the measure.
NA	*Small Denominator.* The organization followed the specifications, but the denominator was too small <30 to report a valid rate. a. For EOC and EOC-like measures, when the denominator is <30; and for HAI, when Total Inpatient Discharges is < 30. b. For utilization measures that count member months, when the denominator is <360 member months. c. For all risk-adjusted utilization measures, except PCR, when the denominator is <150.
NB	*No Benefit.* The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).

[B-2] The term "IS" was broadly used to include the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation also included a review of any manual processes used for HEDIS reporting. The LOs determined whether the MMA plans had the automated systems, information management practices, and processing environment and control procedures in place to capture, access, translate, analyze, and report each HEDIS measure.

[B-3] National Committee for Quality Assurance. *HEDIS® 2018, Volume 5: HEDIS Compliance Audit Standards, Policies and Procedures*. Washington D.C: NCQA; 2017.

Audit Designation Result	Definition
NR	*Not Reported.* The organization chose not to report the measure.
NQ	*Not Required.* The organization was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., *Board Certification*).

For measures reported as percentages, NCQA defined "significant bias" as a deviation of more than 5 percentage points from the true percentage. For measures with multiple indicators (e.g., *Well-Child Visits in the First 15 Months of Life* [*W15*]), more than one rate is required for HEDIS reporting. It is possible that MMA and LTC plans prepared some rates required by the measure appropriately but had significant bias in others. In those instances, according to NCQA guidelines, plans would receive a *Reportable* (*R*) designation for the measure as a whole, but a *Biased Rate* (*BR*) finding for the significantly biased rates within the measure.

It should be noted that the validation designation for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements found to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *BR* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate and the measure could still be assigned a designation of *R*.

Information Systems Findings

The following is a summary of the Standard and Specialty MMA plans' performance as compared to the NCQA HEDIS IS standards.

IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

All Specialty MMA plans and all but one Standard MMA plan were fully compliant with this standard. One Standard MMA plan was compliant with IS Standard 1.E for laboratory services and data processing; however, this plan's lab vendor did not release human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) lab data to the health plan, due to enrollee confidentiality concerns. As a result, this plan was unable to report the *HIV Viral Load Suppression* (*VLS)* measure and received a *Biased Rate* (*BR*) audit designation for this measure. In general, the plans used industry standard codes submitted on industry standard forms. All required data elements were captured at a sufficient level of specificity for reporting. Adequate policies and procedures were in place to ensure data accuracy and data completeness. Standard and Specialty MMA plans that used a claims processing vendor had sufficient vendor oversight, including review of production and performance reports

according to the vendor. The plans' auditors deemed medical services data sufficient for HEDIS and performance measure reporting.

IS 2.0 Enrollment Data—Data Capture, Transfer, and Entry

All Standard and Specialty MMA plans were fully compliant with this standard. The State provided enrollment information to all MMA plans in an 834 file format. Enrollment systems from the plans captured all elements necessary for data reporting. Sufficient edit checks and validation processes were in place to ensure data accuracy. In addition, MMA plans that used manual processes to enter eligibility information into the enrollment system had adequate audit protocols in place to further ensure data accuracy. All plans reconciled enrollment data against the data received from the State to ensure data completeness. Enrollment data were deemed acceptable by the auditors for HEDIS and performance measure reporting.

IS 3.0 Practitioner Data—Data Capture, Transfer, and Entry

All Standard and Specialty MMA plans were fully compliant with this standard. HSAG noted that the auditors identified no issues in regard to capturing, transferring, or entering provider data. Data entry processes had sufficient edit checks to ensure accuracy and data completeness. Provider information required for reporting was adequately captured by all plans. Provider specialties were fully documented and were mapped to HEDIS provider specialties. Plans that used a vendor for capturing and processing provider data had adequate review processes in place to ensure accuracy and data completeness. The plans' auditors deemed practitioner data sufficient for HEDIS and performance measure reporting.

IS 4.0 Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

Five of the Standard MMA plans and all Specialty MMA plans were fully compliant with this standard. One MMA plan had a minimal impact finding with this standard because exclusion errors were identified with the Prenatal and Postpartum Care and for Comprehensive Diabetes Care measures. Since the total number of exclusions were less than 16, and the other nine exclusions passed, no remediation process was required. The exclusions that were not validated were required to be placed back in the denominator for the two measures, bringing the measures into compliance with IS standard 4.0.In general, the plans' data collection tools captured all fields relevant for HEDIS reporting. Plans using outside vendors for medical record data collection had adequate vendor oversight, including regular quality meetings and various validation activities to ensure that only accurate data were used for measure reporting. For plans that were fully compliant with this standard, medical data abstractions were accurately performed with sufficient edit checks in place to ensure data accuracy. Overall, medical record data were deemed acceptable by the auditors for HEDIS and performance measure reporting.

IS 5.0 Supplemental Data—Capture, Transfer, and Entry

All Standard and Specialty MMA plans were fully compliant with this standard. The plans' auditors noted in the FARs that all nonstandard coding schemes were fully documented and accurately mapped to industry standard codes. For nonstandard and enrollee-reported data sources, proof of service documentation was reviewed, with results showing that all information was accurately captured; therefore, these databases were approved for measure reporting. The auditors also noted that the plans obtained adequate quality oversight at each point of information transfer. The auditors identified no

issues or concerns with the use of supplemental data for the plans. Overall, all supplemental data were deemed acceptable by the auditors for HEDIS and performance measure reporting.

IS 7.0 Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

All Standard and Specialty MMA plans were fully compliant with this standard. All plans contracted with a software vendor with full measure certification status by NCQA for the reported HEDIS measures. The auditors found that each plan had sufficient vendor oversight, ensuring timeliness and accurate data reporting. All plans' data accesses were controlled, and adequate file backup processes were in place. The auditors reviewed the NCQA certification reports for all measures and found no issues. Data sources were sufficiently linked to ensure complete and accurate performance measure rate production. Data integration processes were deemed acceptable by the auditors for HEDIS and performance measure reporting.

Appendix C. Description of LTC Plan Validation Activities

LTC Plan Description of SFY 2017–2018 Validation Activities

LTC Plans

HSAG followed the same process to conduct the PMV process for the LTC plans as for the Standard and Specialty MMA plans. For validation, HSAG obtained a list of the performance measures specified for the LTC plans in the Statewide Medicaid Managed Care (SMMC) contract. Additionally, the measure definitions, measure specifications, and reporting format were reviewed by HSAG prior to the audit.

HSAG prepared a documentation request for each LTC plan's FAR and performance measure report. The performance measure report contains all rates calculated and reported by the LTC plans. According to AHCA's reporting requirements, these rates should also be audited by the LTC plan's auditor.

HSAG conducted a desk review of the FARs and the performance measure reports. The desk review included the following verification tasks:

- Verify that key audit elements were performed by the plan's LO to ensure the audit was conducted in compliance with NCQA policies and procedures.
- Examine evidence that the auditors completed a thorough review of the specific Roadmap components associated with calculating and reporting performance measures outlined by AHCA.
- Identify, that for plans where NCQA's HEDIS Compliance Audits were performed, the IS standards (systems, policies, and procedures) applicable for performance measure reporting were reviewed and results were documented by the auditor.
- Evaluate the auditor's description and audit findings regarding data systems and processes associated with performance measure production for plans where NCQA's HEDIS Compliance Audit procedures were not referenced in the FAR.

HSAG also validated the LTC plans' reporting of the audited rates in the performance measure reports, focusing on the following verification components:

- Compare the audit designation results listed in the FAR to the actual rates reported in the performance measure report to ensure that the designation is appropriately applied.
- Assess the accuracy of the rate calculated based on the denominator and numerator for each measure.
- Evaluate data reasonableness for measures with similar eligible populations.
- Assess the extent to which all data elements are reported according to the requirements listed in the *AHCA Health Plan Report Guide*.

Rate Validity

In addition to ensuring that data were captured, reported, and presented in a uniform manner, HSAG evaluated each LTC plan's IS capabilities for accurate data reporting.

To evaluate the calculation of performance measures, HSAG reviewed data integration, data control, and documentation of performance measure calculations. HSAG validated each of these components and reported on the processes used and the overall findings.

Audit Designations

Each measure reviewed by the LTC plans' auditors received an audit designation result based on the seven NCQA categories listed below. Table B-5 shows NCQA's measure-level audit designation categories.[C-1]

Table B-5—Measure-Level Audit Designation Categories—NCQA

Audit Designation Result	Definition
R	*Reportable.* The organization followed the specifications and produced a reportable rate or result for the measure.
NA	*Small Denominator.* The organization followed the specifications, but the denominator was too small <30 to report a valid rate. a. For EOC and EOC-like measures, when the denominator is <30; and for HAI, when Total Inpatient Discharges is < 30. b. For utilization measures that count member months, when the denominator is <360 member months. c. For all risk-adjusted utilization measures, except PCR, when the denominator is <150.
NB	*No Benefit.* The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reported.* The organization chose not to report the measure.
NQ	*Not Required.* The organization was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., *Board Certification*).

For measures reported as percentages, NCQA defined significant bias as a deviation of more than 5 percentage points from the true percentage. For measures with multiple indicators (e.g., *Well-Child*

[C-1] National Committee for Quality Assurance. *HEDIS® 2018, Volume 5: HEDIS Compliance Audit Standards, Policies and Procedures*. Washington D.C: NCQA; 2017.

Visits in the First 15 Months of Life [*W15*]), more than one rate is required for HEDIS reporting. It is possible that MMA and LTC plans prepared some rates required by the measure appropriately but had significant bias in others. In those instances, according to NCQA guidelines, plans would receive a *Reportable* (*R*) designation for the measure as a whole, but a *Biased Rate* (*BR*) finding for the significantly biased rates within the measure.

It should be noted that the validation designation for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements found to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of *BR* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate and the measure could still be assigned a designation of *R*.

Information Systems Findings

The following is a summary of the LTC plans' performance as compared to the NCQA HEDIS IS standards.

IS 1.0 Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

All LTC plans were fully compliant with this standard. The plans used industry standard codes submitted on industry standard forms. All required data elements were captured at a sufficient level of specificity for reporting. Adequate policies and procedures were in place to ensure data accuracy and data completeness. The LTC plans that used a claims processing vendor had sufficient vendor oversight, including review of production and performance reports according to the vendor. The plans' auditors deemed medical services data sufficient for HEDIS and performance measure reporting.

IS 2.0 Enrollment Data—Data Capture, Transfer, and Entry

All LTC plans were fully compliant with this standard. The State provided enrollment information to all LTC plans in an 834 file format. Enrollment systems from the plans captured all elements necessary for data reporting. Sufficient edit checks and validation processes were in place to ensure data accuracy. In addition, LTC plans that used manual processes to enter eligibility information into the enrollment system had adequate audit protocols in place to further ensure data accuracy. All plans reconciled enrollment data against the data received from the State to ensure data completeness. Enrollment data were deemed acceptable by the auditors for HEDIS and performance measure reporting.

IS 3.0 Practitioner Data—Data Capture, Transfer, and Entry

All LTC plans were fully compliant with this standard. HSAG noted that the auditors identified no issues in regard to capturing, transferring, or entering provider data. Data entry processes had sufficient edit checks to ensure accuracy and data completeness. Provider information required for reporting was adequately captured by all plans. Provider specialties were fully documented and were mapped to HEDIS provider specialties. Plans that used a vendor for capturing and processing provider data had adequate review processes in place to ensure accuracy and data completeness. The plans' auditors deemed practitioner data sufficient for HEDIS and performance measure reporting.

IS 4.0 Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

All LTC plans were fully compliant with this standard. In general, the plans' data collection tools captured all fields relevant for HEDIS reporting. Plans using outside vendors for medical record data collection had adequate vendor oversight, including regular quality meetings and various validation activities to ensure that only accurate data were used for measure reporting. For all LTC plans, medical data abstractions were accurately performed with sufficient edit checks in place to ensure data accuracy. Overall, medical record data were deemed acceptable by the auditors for HEDIS and performance measure reporting.

IS 5.0 Supplemental Data—Capture, Transfer, and Entry

All LTC plans were fully compliant with this standard. The plans' auditors noted in the FARs that all nonstandard coding schemes were fully documented and accurately mapped to industry standard codes. For nonstandard and enrollee-reported data sources, proof of service documentation was reviewed, with results showing that all information was accurately captured; therefore, these databases were approved for measure reporting. The auditors also noted that the plans obtained adequate quality oversight at each point of information transfer. The auditors identified no issues or concerns with the use of supplemental data for the plans. Overall, all supplemental data were deemed acceptable by the auditors for HEDIS and performance measure reporting.

IS 7.0 Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

All LTC plans were fully compliant with this standard. All plans contracted with a software vendor with full measure certification status by NCQA for the reported HEDIS measures. The auditors found that each plan had sufficient vendor oversight, ensuring timeliness and accurate data reporting. All plans' data accesses were controlled, and adequate file backup processes were in place. The auditors reviewed the NCQA certification reports for all measures and found no issues. Data sources were sufficiently linked to ensure complete and accurate performance measure rate production. Data integration processes were deemed acceptable by the auditors for HEDIS and performance measure reporting.

Appendix D. MMA Plan-Specific Results

Appendix D includes the RY 2018 results for the Standard and Specialty MMA plans, along with the percentile ranking for each RY 2018 rate. MMA plan performance measure results were compared to national Medicaid Quality Compass HEDIS 2017 benchmarks, when available.

Aetna Better Health

Table D-1—RY 2018 Results—Aetna Better Health

Aetna Better Health Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	0.31%	□□□□□
One Well-Child Visit	0.00%	□
Two Well-Child Visits	1.25%	□
Three Well-Child Visits	2.80%	□
Four Well-Child Visits	3.74%	□
Five Well-Child Visits	11.21%	□
Six or More Well-Child Visits	80.69%	□□□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	85.47%	□□□□□
Childhood Immunization Status		
Combination 2	80.54%	□□□□
Combination 3	77.62%	□□□□
Lead Screening in Children		
Lead Screening in Children	76.64%	□□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	39.37%	□□
Continuation and Maintenance Phase	50.00%	□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	90.30%	□□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	61.56%	□□□□
Immunizations for Adolescents		
Combination 1	74.21%	□□
Combination 2	36.74%	NC
Annual Dental Visit		
2–3 Years	32.17%	□□
4–6 Years	54.09%	□□
7–10 Years	59.85%	□
11–14 Years	53.87%	□□
15–18 Years	43.82%	□□

Aetna Better Health Measures	RY 2018	2018 Performance Level
19–20 Years	28.66%	□□
Total	48.95%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	25.48%	NC

Aetna Better Health Measures	RY 2018	2018 Performance Level
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	63.66%	□□□
Chlamydia Screening in Women		
16–20 Years	69.82%	□□□□□
21–24 Years	68.78%	□□□
Total	69.58%	□□□□
Breast Cancer Screening		
Breast Cancer Screening	67.28%	NC
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	92.37%	□□□□□
Postpartum Care	69.47%	□□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	25.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	4.76%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	11.05%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	34.08%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	6.49%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	87.83%	□□□
*HbA1c Poor Control (>9.0%)**	39.90%	□□□
HbA1c Control (<8.0%)	51.82%	□□□
Eye Exam (Retinal) Performed	55.96%	□□□
Medical Attention for Nephropathy	93.67%	□□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	66.15%	□□□□
Adult BMI Assessment		
Adult BMI Assessment	93.71%	□□□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	49.41%	□□
Medication Compliance 50%—Ages 12–18 Years[1]	44.32%	□
Medication Compliance 50%—Ages 19–50 Years[1]	59.09%	□□
Medication Compliance 50%—Ages 51–64 Years[1]	70.00%	□□

Aetna Better Health Measures	RY 2018	2018 Performance Level
Medication Compliance 50%—Total[1]	51.20%	▯
Medication Compliance 75%—Ages 5–11 Years	29.41%	▯▯▯
Medication Compliance 75%—Ages 12–18 Years	23.86%	▯▯
Medication Compliance 75%—Ages 19–50 Years	31.82%	▯
Medication Compliance 75%—Ages 51–64 Years	56.67%	▯▯▯▯
Medication Compliance 75%—Total	30.72%	▯▯
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	94.18%	▯▯▯▯▯
Diuretics	94.33%	▯▯▯▯▯
Total	94.23%	NC
Plan All-Cause Readmissions		
*18–44 Years**	13.21%	NC
*45–54 Years**	25.86%	NC
*55–64 Years**	16.83%	NC
*18–64 Years—Total**	17.43%	NC
*65–74 Years**	14.89%	NC
*75-84 Years**	7.89%	NC
*85+ Years**	NA	NC
*65+ Years—Total**	13.27%	NC
HIV Viral Load Suppression		
18–64 Years	19.63%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	41.18%	NC
Initiation of AOD Treatment—Total—18+ Years	33.51%	NC
Initiation of AOD Treatment—Total—Total	34.40%	NC
Engagement of AOD Treatment—Total—13–17 Years	19.61%	NC
Engagement of AOD Treatment—Total—18+ Years	4.42%	NC
Engagement of AOD Treatment—Total—Total	6.19%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	38.98%	NC
30-Day Follow-Up	57.80%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	27.96%	▯

Aetna Better Health Measures	RY 2018	2018 Performance Level
30-Day Follow-Up	46.24%	□□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	NA	NC
7-Day Follow-Up—18+ Years	15.38%	□□□
7-Day Follow-Up—Total	12.50%	□□□
30-Day Follow-Up—13–17 Years	NA	NC
30-Day Follow-Up—18+ Years	16.92%	□□□
30-Day Follow-Up—Total	13.75%	□□
Antidepressant Medication Management		
Effective Acute Phase Treatment	53.85%	□□□
Effective Continuation Phase Treatment	34.34%	□□
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	50.29%	□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	62.16%	□□□□□
Total	53.85%	□□□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	NA	NC
*12–17 Years**	NA	NC
*Total**	3.23%	□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	57.89%	□□
Total	62.50%	□□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	21.47%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.63%	□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	97.22%	□□□□
25 Months–6 Years	93.11%	□□□□
7–11 Years	92.32%	□□□
12–19 Years	87.97%	□□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	68.87%	□
45–64 Years	84.31%	□□
65+ Years	88.49%	□□□
Total	75.84%	□

Aetna Better Health Measures	RY 2018	2018 Performance Level
Call Answer Timeliness		
Call Answer Timeliness	87.82%	□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	356.73	NC
*ED Visits—Total**	62.75	□□
Use of Opioids at High Dosage (per 1,000 Member Months)		
*Use of Opioids at High Dosage**	167.27	NC
Use of Opioids From Multiple Providers (per 1,000 Member Months)		
*Multiple Prescribers**	177.33	NC
*Multiple Pharmacies**	114.83	NC
*Multiple Prescribers and Multiple Pharmacies**	58.14	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Amerigroup

Table D-2—RY 2018 Results—Amerigroup

Amerigroup Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	1.22%	□□□
One Well-Child Visit	1.95%	□□□
Two Well-Child Visits	1.46%	□
Three Well-Child Visits	3.41%	□
Four Well-Child Visits	6.08%	□
Five Well-Child Visits	14.11%	□□
Six or More Well-Child Visits	71.78%	□□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	85.40%	□□□□□
Childhood Immunization Status		
Combination 2	82.48%	□□□□□
Combination 3	77.13%	□□□□
Lead Screening in Children		
Lead Screening in Children	73.48%	□□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	50.53%	□□□
Continuation and Maintenance Phase	67.54%	□□□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	89.29%	□□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	64.48%	□□□□
Immunizations for Adolescents		
Combination 1	75.91%	□□
Combination 2	36.50%	NC
Annual Dental Visit		
2–3 Years	28.15%	□
4–6 Years	53.82%	□□
7–10 Years	63.83%	□□
11–14 Years	57.88%	□□
15–18 Years	49.69%	□□
19–20 Years	30.52%	□□
Total	52.34%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	27.57%	NC
Women's Care		
Cervical Cancer Screening		

Amerigroup Measures	RY 2018	2018 Performance Level
Cervical Cancer Screening	61.07%	□□□
Chlamydia Screening in Women		
16–20 Years	65.16%	□□□□
21–24 Years	75.65%	□□□□□
Total	67.49%	□□□□
Breast Cancer Screening		
Breast Cancer Screening	62.57%	NC
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	83.21%	□□
Postpartum Care	65.21%	□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	0.56%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	36.59%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	8.10%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	13.55%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	41.38%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.08%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	6.85%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	87.35%	□□□
*HbA1c Poor Control (>9.0%)**	37.23%	□□□
HbA1c Control (<8.0%)	49.39%	□□□
Eye Exam (Retinal) Performed	55.96%	□□□
Medical Attention for Nephropathy	92.46%	□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	69.59%	□□□□
Adult BMI Assessment		
Adult BMI Assessment	95.86%	□□□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	54.78%	□□□
Medication Compliance 50%—Ages 12–18 Years[1]	54.17%	□□□
Medication Compliance 50%—Ages 19–50 Years[1]	58.22%	□□
Medication Compliance 50%—Ages 51–64 Years[1]	75.32%	□□□
Medication Compliance 50%—Total[1]	55.69%	□□
Medication Compliance 75%—Ages 5–11 Years	25.21%	□□
Medication Compliance 75%—Ages 12–18 Years	24.51%	□□

Amerigroup Measures	RY 2018	2018 Performance Level
Medication Compliance 75%—Ages 19–50 Years	32.03%	▯
Medication Compliance 75%—Ages 51–64 Years	38.31%	▯
Medication Compliance 75%—Total	26.11%	▯
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	92.86%	▯▯▯▯▯
Diuretics	92.90%	▯▯▯▯▯
Total	92.88%	NC
Plan All-Cause Readmissions		
*18–44 Years**	17.57%	NC
*45–54 Years**	24.92%	NC
*55–64 Years**	26.70%	NC
*18–64 Years—Total**	22.04%	NC
*65–74 Years**	20.56%	NC
*75-84 Years**	12.30%	NC
*85+ Years**	15.69%	NC
*65+ Years—Total**	17.31%	NC
HIV Viral Load Suppression		
18–64 Years	17.43%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	75.57%	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	76.81%	▯▯
Discussing Cessation Medications—18–64 Years	51.15%	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	51.45%	▯▯▯
Discussing Cessation Strategies—18–64 Years	47.33%	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	47.10%	▯▯▯
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	41.56%	NC
Initiation of AOD Treatment—Total—18+ Years	39.16%	NC
Initiation of AOD Treatment—Total—Total	39.45%	NC
Engagement of AOD Treatment—Total—13–17 Years	10.89%	NC
Engagement of AOD Treatment—Total—18+ Years	5.50%	NC
Engagement of AOD Treatment—Total—Total	6.15%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	37.92%	NC
30-Day Follow-Up	59.11%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	29.82%	▯▯
30-Day Follow-Up	44.96%	▯
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	3.33%	▯▯
7-Day Follow-Up—18+ Years	5.32%	▯

Amerigroup Measures	RY 2018	2018 Performance Level
7-Day Follow-Up—Total	5.03%	▯
30-Day Follow-Up—13–17 Years	8.89%	▯▯
30-Day Follow-Up—18+ Years	7.98%	▯
30-Day Follow-Up—Total	8.12%	▯
Antidepressant Medication Management		
Effective Acute Phase Treatment	50.05%	▯▯
Effective Continuation Phase Treatment	33.51%	▯▯
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	60.16%	▯▯
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	30.51%	▯▯▯
12–17 Years	39.54%	▯▯▯
Total	36.05%	▯▯▯
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	1.39%	▯▯▯
*12–17 Years**	1.59%	▯▯▯
*Total**	1.51%	▯▯▯
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	68.53%	▯▯▯
12–17 Years	67.57%	▯▯▯
Total	67.83%	▯▯▯
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	39.50%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.68%	▯▯▯
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	95.60%	▯▯
25 Months–6 Years	90.78%	▯▯▯▯
7–11 Years	91.02%	▯▯▯
12–19 Years	88.06%	▯▯
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	68.40%	▯
45–64 Years	84.89%	▯▯
65 Years and Older	88.15%	▯▯▯
Total	73.96%	▯
Call Answer Timeliness		
Call Answer Timeliness	88.24%	▯▯▯
Use of Services		

Amerigroup Measures	RY 2018	2018 Performance Level
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	300.42	NC
*ED Visits—Total**	63.95	□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	114.92	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	217.23	NC
*Multiple Pharmacies**	54.12	NC
*Multiple Prescribers and Multiple Pharmacies**	33.35	NC

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness, and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Better Health

Table D-3—RY 2018 Results—Better Health

Better Health Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	1.95%	□□
One Well-Child Visit	2.19%	□□□
Two Well-Child Visits	2.43%	□□
Three Well-Child Visits	3.41%	□
Four Well-Child Visits	8.03%	□□
Five Well-Child Visits	14.60%	□□
Six or More Well-Child Visits	67.40%	□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.37%	□□□
Childhood Immunization Status		
Combination 2	73.48%	□□
Combination 3	70.80%	□□
Lead Screening in Children		
Lead Screening in Children	70.56%	□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	38.11%	□
Continuation and Maintenance Phase	47.13%	□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	84.67%	□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	57.91%	□□□
Immunizations for Adolescents		
Combination 1	75.43%	□□
Combination 2	27.01%	NC
Annual Dental Visit		
2–3 Years	39.69%	□□□
4–6 Years	60.24%	□□
7–10 Years	67.79%	□□□
11–14 Years	57.95%	□□
15–18 Years	46.00%	□□
19–20 Years	26.75%	□
Total	55.09%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	33.98%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	61.07%	□□□
Chlamydia Screening in Women		

Better Health Measures	RY 2018	2018 Performance Level
16–20 Years	63.15%	□□□□
21–24 Years	67.05%	□□□
Total	64.11%	□□□
Breast Cancer Screening		
Breast Cancer Screening	57.49%	NC

Better Health Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	84.18%	□□□
Postpartum Care	69.83%	□□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	29.69%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	2.08%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	9.46%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	31.08%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	2.81%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	84.43%	□□
*HbA1c Poor Control (>9.0%)**	39.90%	□□□
HbA1c Control (<8.0%)	48.66%	□□
Eye Exam (Retinal) Performed	49.64%	□□
Medical Attention for Nephropathy	93.43%	□□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	55.23%	□□
Adult BMI Assessment		
Adult BMI Assessment	87.83%	□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	51.77%	□□
Medication Compliance 50%—Ages 12–18 Years[1]	48.89%	□□
Medication Compliance 50%—Ages 19–50 Years[1]	65.67%	□□□
Medication Compliance 50%—Ages 51–64 Years[1]	76.47%	□□□
Medication Compliance 50%—Total[1]	53.70%	□□
Medication Compliance 75%—Ages 5–11 Years	22.89%	□□
Medication Compliance 75%—Ages 12–18 Years	24.44%	□□
Medication Compliance 75%—Ages 19–50 Years	32.84%	□□
Medication Compliance 75%—Ages 51–64 Years	47.06%	□□
Medication Compliance 75%—Total	25.62%	□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	92.71%	□□□□
Diuretics	92.52%	□□□□□
Total	92.64%	NC

Better Health Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	23.02%	NC
*45–54 Years**	16.94%	NC
*55–64 Years**	22.78%	NC
*18–64 Years—Total**	21.72%	NC
*65–74 Years**	14.55%	NC
*75-84 Years**	7.50%	NC
*85+ Years**	13.16%	NC
*65+ Years—Total**	12.03%	NC
HIV Viral Load Suppression		
18–64 Years	0.00%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	22.78%	NC
Initiation of AOD Treatment—Total—18+ Years	32.04%	NC
Initiation of AOD Treatment—Total—Total	31.30%	NC
Engagement of AOD Treatment—Total—13–17 Years	5.06%	NC
Engagement of AOD Treatment—Total—18+ Years	3.20%	NC
Engagement of AOD Treatment—Total—Total	3.35%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	24.33%	NC
30-Day Follow-Up	44.16%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	22.17%	□
30-Day Follow-Up	36.95%	□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	NA	NC
7-Day Follow-Up—18+ Years	4.95%	□
7-Day Follow-Up—Total	4.46%	□
30-Day Follow-Up—13–17 Years	NA	NC
30-Day Follow-Up—18+ Years	6.04%	□
30-Day Follow-Up—Total	5.45%	□
Antidepressant Medication Management		
Effective Acute Phase Treatment	48.31%	□□
Effective Continuation Phase Treatment	34.53%	□□

Better Health Measures	RY 2018	2018 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	56.84%	□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	34.55%	□□□
12–17 Years	49.47%	□□□□□
Total	44.00%	□□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	0.00%	□□□□□
*12–17 Years**	5.56%	□
*Total**	3.77%	□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	66.67%	□□□
12–17 Years	57.58%	□□
Total	60.61%	□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	20.78%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.58%	□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	93.72%	□□
25 Months–6 Years	85.07%	□□
7–11 Years	87.19%	□
12–19 Years	81.26%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	59.33%	□
45–64 Years	80.70%	□
65 Years and Older	83.74%	□□
Total	67.27%	□
Call Answer Timeliness		
Call Answer Timeliness	95.03%	□□□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	267.56	NC
*ED Visits—Total**	65.20	□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	122.64	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	774.87	NC

Better Health Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	774.87	NC
*Multiple Prescribers and Multiple Pharmacies**	774.87	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Children's Medical Services–S

Table D-4—RY 2018 Results—Children's Medical Services–S

Children's Medical Services-S Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	0.00%	□□□□□
One Well-Child Visit	1.56%	□□
Two Well-Child Visits	3.13%	□□□
Three Well-Child Visits	4.69%	□□
Four Well-Child Visits	18.75%	□□□□□
Five Well-Child Visits	17.19%	□□□
Six or More Well-Child Visits	54.69%	□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.83%	□□□
Childhood Immunization Status		
Combination 2	77.13%	□□□
Combination 3	72.51%	□□□
Lead Screening in Children		
Lead Screening in Children	62.29%	□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	37.89%	□
Continuation and Maintenance Phase	51.90%	□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	68.13%	□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	59.49%	□□□
Immunizations for Adolescents		
Combination 1	76.89%	□□
Combination 2	31.14%	NC
Annual Dental Visit		
2–3 Years	37.77%	□□
4–6 Years	51.26%	□
7–10 Years	59.19%	□
11–14 Years	55.45%	□□
15–18 Years	48.69%	□□
19–20 Years	36.04%	□□
Total	52.36%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	20.04%	NC
Women's Care		
Chlamydia Screening in Women		
16–20 Years	45.19%	□
21–24 Years	NA	NC

Children's Medical Services-S Measures	RY 2018	2018 Performance Level
Total	45.19%	▯
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	50.00%	▯
Postpartum Care	45.65%	▯
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	35.71%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	7.14%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	79.77%	▯
*HbA1c Poor Control (>9.0%)**	100.00%	▯
HbA1c Control (<8.0%)	0.00%	▯
Eye Exam (Retinal) Performed	44.36%	▯
Medical Attention for Nephropathy	74.71%	▯
Adult BMI Assessment		
Adult BMI Assessment	25.72%	▯
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	57.02%	▯▯▯
Medication Compliance 50%—Ages 12–18 Years[1]	59.28%	▯▯▯▯
Medication Compliance 50%—Ages 19–50 Years[1]	64.35%	▯▯▯
Medication Compliance 50%—Ages 51–64 Years[1]	NA	NC
Medication Compliance 50%—Total[1]	58.33%	▯▯▯
Medication Compliance 75%—Ages 5–11 Years	30.64%	▯▯▯
Medication Compliance 75%—Ages 12–18 Years	33.09%	▯▯▯▯
Medication Compliance 75%—Ages 19–50 Years	42.61%	▯▯▯
Medication Compliance 75%—Ages 51–64 Years	NA	NC
Medication Compliance 75%—Total	32.23%	▯▯
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	86.67%	▯▯
Diuretics	NA	NC
Total	84.87%	NC
HIV Viral Load Suppression		
18–64 Years	0.00%	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	54.00%	NC
Initiation of AOD Treatment—Total—18+ Years	40.79%	NC
Initiation of AOD Treatment—Total—Total	48.30%	NC
Engagement of AOD Treatment—Total—13–17 Years	13.00%	NC
Engagement of AOD Treatment—Total—18+ Years	3.95%	NC

Children's Medical Services-S Measures	RY 2018	2018 Performance Level
Engagement of AOD Treatment—Total—Total	9.09%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	38.73%	NC
30-Day Follow-Up	63.47%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	46.15%	□□□
30-Day Follow-Up	65.38%	□□□□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	NA	NC
7-Day Follow-Up—18+ Years	NA	NC
7-Day Follow-Up—Total	0.00%	□
30-Day Follow-Up—13–17 Years	NA	NC
30-Day Follow-Up—18+ Years	NA	NC
30-Day Follow-Up—Total	3.03%	□
Antidepressant Medication Management		
Effective Acute Phase Treatment	65.52%	□□□□□
Effective Continuation Phase Treatment	39.66%	□□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	76.67%	□□□□□
6–11 Years	36.80%	□□□□
12–17 Years	44.65%	□□□□
Total	42.06%	□□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	2.80%	□
*12–17 Years**	3.27%	□□
*Total**	3.05%	□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	50.53%	□
12–17 Years	58.28%	□□
Total	55.56%	□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	62.15%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	68.24%	□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	97.77%	□□□□
25 Months–6 Years	94.60%	□□□□□
7–11 Years	96.66%	□□□□□
12–19 Years	95.31%	□□□□□
Call Answer Timeliness		

Children's Medical Services-S Measures	RY 2018	2018 Performance Level
Call Answer Timeliness	77.71%	□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	485.84	NC
*ED Visits—Total**	71.19	□□

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness, and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Clear Health–S

Table D-5—RY 2018 Results—Clear Health–S

Clear Health-S Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	NA	NC
One Well-Child Visit	NA	NC
Two Well-Child Visits	NA	NC
Three Well-Child Visits	NA	NC
Four Well-Child Visits	NA	NC
Five Well-Child Visits	NA	NC
Six or More Well-Child Visits	NA	NC
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.93%	□□□
Childhood Immunization Status		
Combination 2	NA	NC
Combination 3	NA	NC
Lead Screening in Children		
Lead Screening in Children	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NA	NC
Continuation and Maintenance Phase	NA	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	80.43%	□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	56.58%	□□□
Immunizations for Adolescents		
Combination 1	NA	NC
Combination 2	NA	NC
Annual Dental Visit		
2–3 Years	NA	NC
4–6 Years	38.64%	□
7–10 Years	NA	NC
11–14 Years	NA	NC
15–18 Years	NA	NC
19–20 Years	NA	NC
Total	36.76%	□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	NA	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	70.07%	□□□□
Chlamydia Screening in Women		
16–20 Years	NA	NC
21–24 Years	81.36%	□□□□□

Clear Health-S Measures	RY 2018	2018 Performance Level
Total	79.75%	□□□□□
Breast Cancer Screening		
Breast Cancer Screening	54.77%	NC

Clear Health-S Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	73.74%	▯
Postpartum Care	69.70%	▯▯▯▯
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	NA	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	NA	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	NA	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	NA	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	19.79%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	36.46%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	1.04%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	86.13%	▯▯
*HbA1c Poor Control (>9.0%)**	47.93%	▯▯
HbA1c Control (<8.0%)	46.96%	▯▯
Eye Exam (Retinal) Performed	39.66%	▯
Medical Attention for Nephropathy	94.89%	▯▯▯▯▯
Controlling High Blood Pressure		
Controlling High Blood Pressure	47.93%	▯▯
Adult BMI Assessment		
Adult BMI Assessment	91.00%	▯▯▯▯
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	NA	NC
Medication Compliance 50%—Ages 12–18 Years[1]	NA	NC
Medication Compliance 50%—Ages 19–50 Years[1]	75.00%	▯▯▯▯▯
Medication Compliance 50%—Ages 51–64 Years[1]	81.40%	▯▯▯▯
Medication Compliance 50%—Total[1]	77.57%	▯▯▯▯▯
Medication Compliance 75%—Ages 5–11 Years	NA	NC
Medication Compliance 75%—Ages 12–18 Years	NA	NC
Medication Compliance 75%—Ages 19–50 Years	45.31%	▯▯▯▯
Medication Compliance 75%—Ages 51–64 Years	60.47%	▯▯▯▯
Medication Compliance 75%—Total	51.40%	▯▯▯▯▯
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	99.14%	▯▯▯▯▯
Diuretics	98.80%	▯▯▯▯▯
Total	99.01%	NC

Clear Health-S Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	36.43%	NC
*45–54 Years**	27.73%	NC
*55–64 Years**	26.32%	NC
*18–64 Years—Total**	30.05%	NC
*65–74 Years**	NA	NC
*75-84 Years**	NA	NC
*85+ Years**	NA	NC
*65+ Years—Total**	NA	NC
HIV Viral Load Suppression		
18–64 Years	0.00%	NC
65+ Years	0.00%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	88.96%	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	89.30%	□□□□□
Discussing Cessation Medications—18–64 Years	69.03%	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	69.39%	□□□□□
Discussing Cessation Strategies—18–64 Years	64.05%	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	65.03%	□□□□□
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	NA	NC
Initiation of AOD Treatment—Total—18+ Years	45.47%	NC
Initiation of AOD Treatment—Total—Total	45.47%	NC
Engagement of AOD Treatment—Total—13–17 Years	NA	NC
Engagement of AOD Treatment—Total—18+ Years	2.50%	NC
Engagement of AOD Treatment—Total—Total	2.50%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	12.44%	NC
30-Day Follow-Up	24.53%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	11.70%	□
30-Day Follow-Up	28.72%	□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	NA	NC
7-Day Follow-Up—18+ Years	5.19%	□
7-Day Follow-Up—Total	5.19%	□
30-Day Follow-Up—13–17 Years	NA	NC
30-Day Follow-Up—18+ Years	7.41%	□
30-Day Follow-Up—Total	7.41%	□
Antidepressant Medication Management		
Effective Acute Phase Treatment	51.76%	□□
Effective Continuation Phase Treatment	41.55%	□□□

Clear Health-S Measures	RY 2018	2018 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	45.38%	▯
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	NA	NC
Total	NA	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	NA	NC
*12–17 Years**	NA	NC
*Total**	NA	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	NA	NC
Total	NA	NC
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	45.60%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	97.99%	▯▯▯▯▯
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NA	NC
25 Months–6 Years	62.30%	▯
7–11 Years	NA	NC
12–19 Years	NA	NC
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	84.03%	▯▯▯▯
45–64 Years	94.33%	▯▯▯▯▯
65 Years and Older	92.96%	▯▯▯▯
Total	91.09%	▯▯▯▯▯
Call Answer Timeliness		
Call Answer Timeliness	96.41%	▯▯▯▯▯
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	411.87	NC
*ED Visits—Total**	149.04	▯
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	162.91	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	779.85	NC
*Multiple Pharmacies**	779.85	NC
*Multiple Prescribers and Multiple Pharmacies**	779.85	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Community Care Plan

Table D-6—RY 2018 Results—Community Care Plan

Community Care Plan Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	1.69%	□□
One Well-Child Visit	2.26%	□□□
Two Well-Child Visits	2.26%	□□
Three Well-Child Visits	5.08%	□□□
Four Well-Child Visits	4.80%	□
Five Well-Child Visits	11.58%	□
Six or More Well-Child Visits	72.32%	□□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	81.54%	□□□□
Childhood Immunization Status		
Combination 2	78.10%	□□□
Combination 3	72.51%	□□□
Lead Screening in Children		
Lead Screening in Children	76.40%	□□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	41.42%	□□
Continuation and Maintenance Phase	NA	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	86.13%	□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	56.79%	□□□
Immunizations for Adolescents		
Combination 1	82.73%	□□□
Combination 2	33.33%	NC
Annual Dental Visit		
2–3 Years	40.72%	□□□
4–6 Years	58.35%	□□
7–10 Years	66.01%	□□□
11–14 Years	57.07%	□□
15–18 Years	43.06%	□
19–20 Years	24.26%	□
Total	54.37%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	26.12%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	58.15%	□□
Chlamydia Screening in Women		

Community Care Plan Measures	RY 2018	2018 Performance Level
16–20 Years	66.08%	□□□□
21–24 Years	70.97%	□□□□
Total	67.13%	□□□□
Breast Cancer Screening		
Breast Cancer Screening	61.88%	NC

Community Care Plan Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	85.40%	□□□
Postpartum Care	71.78%	□□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	16.13%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	0.00%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	10.82%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	31.97%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	1.62%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	88.08%	□□□
*HbA1c Poor Control (>9.0%)**	36.01%	□□□
HbA1c Control (<8.0%)	53.77%	□□□□
Eye Exam (Retinal) Performed	66.42%	□□□□
Medical Attention for Nephropathy	93.43%	□□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	63.50%	□□□
Adult BMI Assessment		
Adult BMI Assessment	90.41%	□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	52.28%	□□
Medication Compliance 50%—Ages 12–18 Years[1]	45.45%	□
Medication Compliance 50%—Ages 19–50 Years[1]	NA	NC
Medication Compliance 50%—Ages 51–64 Years[1]	NA	NC
Medication Compliance 50%—Total[1]	50.87%	□
Medication Compliance 75%—Ages 5–11 Years	22.84%	□□
Medication Compliance 75%—Ages 12–18 Years	15.45%	□
Medication Compliance 75%—Ages 19–50 Years	NA	NC
Medication Compliance 75%—Ages 51–64 Years	NA	NC
Medication Compliance 75%—Total	22.54%	□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	93.61%	□□□□□
Diuretics	93.85%	□□□□□
Total	93.70%	NC

Community Care Plan Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	22.18%	NC
*45–54 Years**	15.93%	NC
*55–64 Years**	26.32%	NC
*18–64 Years—Total**	22.45%	NC
*65–74 Years**	NA	NC
*75-84 Years**	NA	NC
*85+ Years**	NA	NC
*65+ Years—Total**	6.78%	NC
HIV Viral Load Suppression		
18–64 Years	12.50%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	28.21%	NC
Initiation of AOD Treatment—Total—18+ Years	35.31%	NC
Initiation of AOD Treatment—Total—Total	34.54%	NC
Engagement of AOD Treatment—Total—13–17 Years	5.13%	NC
Engagement of AOD Treatment—Total—18+ Years	5.94%	NC
Engagement of AOD Treatment—Total—Total	5.85%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	35.56%	NC
30-Day Follow-Up	56.44%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	20.65%	□
30-Day Follow-Up	33.70%	□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	NA	NC
7-Day Follow-Up—18+ Years	11.84%	□□□
7-Day Follow-Up—Total	10.71%	□□
30-Day Follow-Up—13–17 Years	NA	NC
30-Day Follow-Up—18+ Years	11.84%	□□
30-Day Follow-Up—Total	10.71%	□□
Antidepressant Medication Management		
Effective Acute Phase Treatment	55.00%	□□□
Effective Continuation Phase Treatment	42.50%	□□□□

Community Care Plan Measures	RY 2018	2018 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	55.29%	□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	56.10%	□□□□□
Total	50.85%	□□□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	NA	NC
*12–17 Years**	NA	NC
*Total**	4.76%	□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	NA	NC
Total	56.76%	□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	20.06%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.08%	□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	94.23%	□□
25 Months–6 Years	88.03%	□□□
7–11 Years	89.95%	□□
12–19 Years	83.36%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	55.41%	□
45–64 Years	76.91%	□
65 Years and Older	83.10%	□□
Total	63.87%	□
Call Answer Timeliness		
Call Answer Timeliness	90.32%	□□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	282.31	NC
*ED Visits—Total**	60.48	□□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	115.50	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	229.21	NC

Community Care Plan Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	87.64	NC
*Multiple Prescribers and Multiple Pharmacies**	65.17	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Freedom–S

Table D-7—RY 2018 Results—Freedom–S

Freedom-S Measures	RY 2018	2018 Performance Level
Women's Care		
Breast Cancer Screening		
Breast Cancer Screening	NA	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	NA	NC
*HbA1c Poor Control (>9.0%)**	NA	NC
HbA1c Control (<8.0%)	NA	NC
Eye Exam (Retinal) Performed	NA	NC
Medical Attention for Nephropathy	NA	NC
Controlling High Blood Pressure		
Controlling High Blood Pressure	62.50%	□□□
Adult BMI Assessment		
Adult BMI Assessment	NA	NC
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	97.56%	□□□□□
Diuretics	NA	NC
Total	97.01%	NC
Plan All-Cause Readmissions		
*18–44 Years**	NA	NC
*45–54 Years**	NA	NC
*55–64 Years**	NA	NC
*18–64 Years—Total**	NA	NC
*65–74 Years**	NA	NC
*75-84 Years**	NA	NC
*85+ Years**	NA	NC
*65+ Years—Total**	NA	NC
HIV Viral Load Suppression		
18–64 Years	NA	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Care for Older Adults		
Advance Care Planning—66+ Years	75.41%	NC
Functional Status Assessment—66+ Years	86.89%	NC

Freedom-S Measures	RY 2018	2018 Performance Level
Medication Review—66+ Years	88.52%	NC
Pain Assessment—66+ Years	90.16%	NC

Freedom-S Measures	RY 2018	2018 Performance Level
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	NA	NC
Initiation of AOD Treatment—Total—18+ Years	NA	NC
Initiation of AOD Treatment—Total—Total	NA	NC
Engagement of AOD Treatment—Total—13–17 Years	NA	NC
Engagement of AOD Treatment—Total—18+ Years	NA	NC
Engagement of AOD Treatment—Total—Total	NA	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	NA	NC
30-Day Follow-Up	NA	NC
Antidepressant Medication Management		
Effective Acute Phase Treatment	NA	NC
Effective Continuation Phase Treatment	NA	NC
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	NA	NC
Access/Availability of Care		
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	NA	NC
45–64 Years	NA	NC
65 Years and Older	93.55%	□□□□
Total	90.79%	□□□□□
Call Answer Timeliness		
Call Answer Timeliness	95.03%	□□□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	310.61	NC
*ED Visits—Total**	53.66	□□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	80.00	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	137.93	NC
*Multiple Pharmacies**	0.00	NC
*Multiple Prescribers and Multiple Pharmacies**	0.00	NC

** For this indicator, a lower rate indicates better performance.*

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Humana

Table D-8—RY 2018 Results—Humana

Humana Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	1.22%	□□□
One Well-Child Visit	1.46%	□□
Two Well-Child Visits	2.19%	□
Three Well-Child Visits	3.65%	□
Four Well-Child Visits	7.06%	□
Five Well-Child Visits	10.46%	□
Six or More Well-Child Visits	73.97%	□□□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	78.83%	□□□□
Childhood Immunization Status		
Combination 2	78.35%	□□□
Combination 3	74.21%	□□□
Lead Screening in Children		
Lead Screening in Children	70.07%	□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	38.21%	□
Continuation and Maintenance Phase	51.37%	□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	89.29%	□□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	55.21%	□□□
Immunizations for Adolescents		
Combination 1	75.91%	□□
Combination 2	35.04%	NC
Annual Dental Visit		
2–3 Years	35.28%	□□
4–6 Years	55.26%	□□
7–10 Years	62.18%	□□
11–14 Years	56.39%	□□
15–18 Years	48.95%	□□
19–20 Years	32.65%	□□
Total	51.93%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	25.00%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	59.61%	□□□
Chlamydia Screening in Women		

Humana Measures	RY 2018	2018 Performance Level
16–20 Years	64.29%	□□□□
21–24 Years	68.24%	□□□
Total	65.43%	□□□□
Breast Cancer Screening		
Breast Cancer Screening	58.53%	NC

Humana Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	79.32%	□□
Postpartum Care	66.91%	□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	34.05%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	5.59%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	8.55%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	37.70%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.03%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	4.91%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	85.89%	□□
*HbA1c Poor Control (>9.0%)**	33.82%	□□□□
HbA1c Control (<8.0%)	52.07%	□□□
Eye Exam (Retinal) Performed	62.04%	□□□
Medical Attention for Nephropathy	92.99%	□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	67.64%	□□□□
Adult BMI Assessment		
Adult BMI Assessment	94.65%	□□□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	48.96%	□□
Medication Compliance 50%—Ages 12–18 Years[1]	47.26%	□□
Medication Compliance 50%—Ages 19–50 Years[1]	63.37%	□□□
Medication Compliance 50%—Ages 51–64 Years[1]	80.23%	□□□□
Medication Compliance 50%—Total[1]	52.83%	□□
Medication Compliance 75%—Ages 5–11 Years	24.75%	□□
Medication Compliance 75%—Ages 12–18 Years	22.33%	□□
Medication Compliance 75%—Ages 19–50 Years	40.48%	□□□
Medication Compliance 75%—Ages 51–64 Years	52.91%	□□□
Medication Compliance 75%—Total	28.42%	□□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	94.66%	□□□□□
Diuretics	94.80%	□□□□□
Total	94.71%	NC

Humana Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	23.13%	NC
*45–54 Years**	22.43%	NC
*55–64 Years**	21.04%	NC
*18–64 Years—Total**	22.27%	NC
*65–74 Years**	15.91%	NC
*75-84 Years**	12.77%	NC
*85+ Years**	10.49%	NC
*65+ Years—Total**	13.44%	NC
HIV Viral Load Suppression		
18–64 Years	9.06%	NC
65+ Years	10.10%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	34.58%	NC
Initiation of AOD Treatment—Total—18+ Years	43.55%	NC
Initiation of AOD Treatment—Total—Total	43.03%	NC
Engagement of AOD Treatment—Total—13–17 Years	10.90%	NC
Engagement of AOD Treatment—Total—18+ Years	5.78%	NC
Engagement of AOD Treatment—Total—Total	6.08%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	32.94%	NC
30-Day Follow-Up	52.21%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	26.58%	□
30-Day Follow-Up	42.67%	□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	5.26%	□□
7-Day Follow-Up—18+ Years	6.19%	□
7-Day Follow-Up—Total	6.09%	□
30-Day Follow-Up—13–17 Years	7.37%	□□
30-Day Follow-Up—18+ Years	9.28%	□
30-Day Follow-Up—Total	9.08%	□
Antidepressant Medication Management		
Effective Acute Phase Treatment	54.97%	□□□
Effective Continuation Phase Treatment	39.16%	□□□

Humana Measures	RY 2018	2018 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.21%	□□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	30.05%	□□□
12–17 Years	42.12%	□□□□
Total	38.10%	□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	0.85%	□□□
*12–17 Years**	2.16%	□□□
*Total**	1.76%	□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	60.36%	□□
12–17 Years	59.66%	□□
Total	59.77%	□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	26.37%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.28%	□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	93.80%	□□
25 Months–6 Years	87.18%	□□
7–11 Years	87.54%	□
12–19 Years	84.08%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	66.41%	□
45–64 Years	86.42%	□□
65 Years and Older	91.38%	□□□□
Total	78.23%	□□
Call Answer Timeliness		
Call Answer Timeliness	99.00%	□□□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	346.95	NC
*ED Visits—Total**	66.60	□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	62.20	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	202.58	NC

Humana Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	75.33	NC
*Multiple Prescribers and Multiple Pharmacies**	42.59	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Magellan–S

Table D-9—RY 2018 Results—Magellan–S

Magellan-S Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	NA	NC
One Well-Child Visit	NA	NC
Two Well-Child Visits	NA	NC
Three Well-Child Visits	NA	NC
Four Well-Child Visits	NA	NC
Five Well-Child Visits	NA	NC
Six or More Well-Child Visits	NA	NC
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	58.82%	□
Childhood Immunization Status		
Combination 2	NA	NC
Combination 3	NA	NC
Lead Screening in Children		
Lead Screening in Children	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	26.62%	□
Continuation and Maintenance Phase	40.91%	□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	77.62%	□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	42.34%	□
Immunizations for Adolescents		
Combination 1	50.85%	□
Combination 2	14.36%	NC
Annual Dental Visit		
2–3 Years	NA	NC
4–6 Years	52.94%	□
7–10 Years	50.27%	□
11–14 Years	38.36%	□
15–18 Years	35.85%	□
19–20 Years	22.39%	□
Total	34.93%	□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	0.00%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	45.74%	□
Chlamydia Screening in Women		
16–20 Years	66.20%	□□□□

Magellan-S Measures	RY 2018	2018 Performance Level
21–24 Years	71.64%	□□□□
Total	67.89%	□□□□
Breast Cancer Screening		
Breast Cancer Screening	40.94%	NC

Magellan-S Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	63.26%	□
Postpartum Care	40.88%	□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	2.07%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	29.31%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	4.48%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	13.15%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	34.26%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.26%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	4.33%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	79.08%	□
*HbA1c Poor Control (>9.0%)**	51.09%	□
HbA1c Control (<8.0%)	40.63%	□
Eye Exam (Retinal) Performed	45.50%	□
Medical Attention for Nephropathy	91.73%	□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	54.99%	□□
Adult BMI Assessment		
Adult BMI Assessment	83.45%	□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	NA	NC
Medication Compliance 50%—Ages 12–18 Years[1]	69.23%	□□□□□
Medication Compliance 50%—Ages 19–50 Years[1]	73.72%	□□□□
Medication Compliance 50%—Ages 51–64 Years[1]	87.34%	□□□□□
Medication Compliance 50%—Total[1]	74.29%	□□□□□
Medication Compliance 75%—Ages 5–11 Years	NA	NC
Medication Compliance 75%—Ages 12–18 Years	49.23%	□□□□□
Medication Compliance 75%—Ages 19–50 Years	58.33%	□□□□□
Medication Compliance 75%—Ages 51–64 Years	70.89%	□□□□□
Medication Compliance 75%—Total	57.68%	□□□□□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	92.11%	□□□□
Diuretics	92.36%	□□□□
Total	92.21%	NC

Magellan-S Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	31.77%	NC
*45–54 Years**	32.51%	NC
*55–64 Years**	30.25%	NC
*18–64 Years—Total**	31.56%	NC
*65–74 Years**	13.67%	NC
*75-84 Years**	16.72%	NC
*85+ Years**	7.41%	NC
*65+ Years—Total**	13.72%	NC
HIV Viral Load Suppression		
18–64 Years	0.00%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	81.60%	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	81.71%	□□□□
Discussing Cessation Medications—18–64 Years	57.06%	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	56.71%	□□□□
Discussing Cessation Strategies—18–64 Years	49.09%	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	48.80%	□□□
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	49.77%	NC
Initiation of AOD Treatment—Total—18+ Years	51.26%	NC
Initiation of AOD Treatment—Total—Total	51.18%	NC
Engagement of AOD Treatment—Total—13–17 Years	5.48%	NC
Engagement of AOD Treatment—Total—18+ Years	6.20%	NC
Engagement of AOD Treatment—Total—Total	6.17%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	23.62%	NC
30-Day Follow-Up	42.27%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	33.69%	□□
30-Day Follow-Up	49.36%	□□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	0.00%	□
7-Day Follow-Up—18+ Years	8.72%	□□
7-Day Follow-Up—Total	8.35%	□□
30-Day Follow-Up—13–17 Years	3.39%	□
30-Day Follow-Up—18+ Years	12.24%	□□
30-Day Follow-Up—Total	11.86%	□□
Antidepressant Medication Management		
Effective Acute Phase Treatment	57.07%	□□□

Magellan-S Measures	RY 2018	2018 Performance Level
Effective Continuation Phase Treatment	43.91%	□□□□
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	66.87%	□□□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	38.74%	□□□□
12–17 Years	36.15%	□□□
Total	36.72%	□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	0.00%	□□□□□
*12–17 Years**	1.94%	□□□
*Total**	1.45%	□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	57.33%	□□
12–17 Years	61.08%	□□
Total	60.36%	□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	46.13%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.67%	□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NA	NC
25 Months–6 Years	82.86%	□
7–11 Years	75.31%	□
12–19 Years	67.73%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	72.55%	□□
45–64 Years	86.39%	□□
65 Years and Older	81.38%	□□
Total	77.76%	□□
Call Answer Timeliness		
Call Answer Timeliness	79.41%	□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	234.71	NC
*ED Visits—Total**	150.77	□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	92.98	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	768.38	NC

Magellan-S Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	768.38	NC
*Multiple Prescribers and Multiple Pharmacies**	768.38	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Molina

Table D-10—RY 2018 Results—Molina

Molina Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	2.01%	□□
One Well-Child Visit	2.76%	□□□□
Two Well-Child Visits	1.76%	□
Three Well-Child Visits	4.27%	□□
Four Well-Child Visits	7.04%	□
Five Well-Child Visits	12.06%	□
Six or More Well-Child Visits	70.10%	□□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.44%	□□□
Childhood Immunization Status		
Combination 2	75.43%	□□□
Combination 3	72.02%	□□□
Lead Screening in Children		
Lead Screening in Children	62.53%	□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	43.69%	□□
Continuation and Maintenance Phase	60.47%	□□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	85.54%	□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	56.45%	□□□
Immunizations for Adolescents		
Combination 1	67.64%	□
Combination 2	28.71%	NC
Annual Dental Visit		
2–3 Years	32.51%	□□
4–6 Years	52.90%	□
7–10 Years	60.22%	□□
11–14 Years	53.22%	□
15–18 Years	45.54%	□□
19–20 Years	28.02%	□
Total	50.06%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	0.00%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	63.99%	□□□
Chlamydia Screening in Women		

Molina Measures	RY 2018	2018 Performance Level
16–20 Years	60.38%	□□□
21–24 Years	72.87%	□□□□
Total	63.90%	□□□
Breast Cancer Screening		
Breast Cancer Screening	65.18%	NC

Molina Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	84.05%	□□□
Postpartum Care	67.09%	□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	1.50%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	37.80%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.23%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	9.13%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	10.53%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	41.22%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.03%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	6.69%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	87.10%	□□□
*HbA1c Poor Control (>9.0%)**	40.39%	□□□
HbA1c Control (<8.0%)	48.91%	□□□
Eye Exam (Retinal) Performed	58.15%	□□□
Medical Attention for Nephropathy	93.19%	□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	50.36%	□□
Adult BMI Assessment		
Adult BMI Assessment	88.21%	□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	50.76%	□□
Medication Compliance 50%—Ages 12–18 Years[1]	51.65%	□□□
Medication Compliance 50%—Ages 19–50 Years[1]	66.87%	□□□□
Medication Compliance 50%—Ages 51–64 Years[1]	77.19%	□□□
Medication Compliance 50%—Total[1]	54.58%	□□
Medication Compliance 75%—Ages 5–11 Years	25.54%	□□
Medication Compliance 75%—Ages 12–18 Years	26.10%	□□
Medication Compliance 75%—Ages 19–50 Years	39.46%	□□□
Medication Compliance 75%—Ages 51–64 Years	52.63%	□□□
Medication Compliance 75%—Total	29.05%	□□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	92.19%	□□□□
Diuretics	92.06%	□□□□
Total	92.14%	NC

Molina Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	18.54%	NC
*45–54 Years**	23.33%	NC
*55–64 Years**	23.77%	NC
*18–64 Years—Total**	21.31%	NC
*65–74 Years**	15.71%	NC
*75-84 Years**	9.40%	NC
*85+ Years**	16.07%	NC
*65+ Years—Total**	13.84%	NC
HIV Viral Load Suppression		
18–64 Years	0.00%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	42.07%	NC
Initiation of AOD Treatment—Total—18+ Years	38.39%	NC
Initiation of AOD Treatment—Total—Total	38.74%	NC
Engagement of AOD Treatment—Total—13–17 Years	5.77%	NC
Engagement of AOD Treatment—Total—18+ Years	6.64%	NC
Engagement of AOD Treatment—Total—Total	6.55%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	28.54%	NC
30-Day Follow-Up	50.33%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	21.44%	□
30-Day Follow-Up	37.76%	□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	3.41%	□□
7-Day Follow-Up—18+ Years	3.77%	□
7-Day Follow-Up—Total	3.73%	□
30-Day Follow-Up—13–17 Years	7.95%	□□
30-Day Follow-Up—18+ Years	5.88%	□
30-Day Follow-Up—Total	6.13%	□
Antidepressant Medication Management		
Effective Acute Phase Treatment	50.49%	□□
Effective Continuation Phase Treatment	36.02%	□□

Molina Measures	RY 2018	2018 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	57.54%	□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	32.28%	□□□
12–17 Years	43.23%	□□□□
Total	39.06%	□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	0.00%	□□□□□
*12–17 Years**	0.89%	□□□□
*Total**	0.56%	□□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	66.29%	□□□
12–17 Years	60.70%	□□
Total	62.63%	□□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	50.28%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.89%	□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	94.44%	□□
25 Months–6 Years	86.63%	□□
7–11 Years	86.30%	□
12–19 Years	82.65%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	69.26%	□
45–64 Years	85.15%	□□
65 Years and Older	87.34%	□□□
Total	75.20%	□
Call Answer Timeliness		
Call Answer Timeliness	97.68%	□□□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	320.10	NC
*ED Visits—Total**	69.29	□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	59.30	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	262.34	NC

Molina Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	79.54	NC
*Multiple Prescribers and Multiple Pharmacies**	51.01	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Positive-S

Table D-11—RY 2018 Results—Positive-S

Positive-S Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	NA	NC
One Well-Child Visit	NA	NC
Two Well-Child Visits	NA	NC
Three Well-Child Visits	NA	NC
Four Well-Child Visits	NA	NC
Five Well-Child Visits	NA	NC
Six or More Well-Child Visits	NA	NC
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NA	NC
Childhood Immunization Status		
Combination 2	NA	NC
Combination 3	NA	NC
Lead Screening in Children		
Lead Screening in Children	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	NA	NC
Continuation and Maintenance Phase	NA	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	NA	NC
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	NA	NC
Immunizations for Adolescents		
Combination 1	NA	NC
Combination 2	NA	NC
Annual Dental Visit		
2–3 Years	NA	NC
4–6 Years	NA	NC
7–10 Years	NA	NC
11–14 Years	NA	NC
15–18 Years	NA	NC
19–20 Years	NA	NC
Total	NA	NC
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	NA	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	68.13%	□□□□
Chlamydia Screening in Women		
16–20 Years	NA	NC
21–24 Years	NA	NC
Total	NA	NC

Positive-S Measures	RY 2018	2018 Performance Level
Breast Cancer Screening		
Breast Cancer Screening	54.17%	NC

Positive-S Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	NA	NC
Postpartum Care	NA	NC
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	NA	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	NA	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	NA	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	NA	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	NA	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	NA	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	NA	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	NA	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	94.20%	□□□□□
*HbA1c Poor Control (>9.0%)**	31.16%	□□□□
HbA1c Control (<8.0%)	65.22%	□□□□□
Eye Exam (Retinal) Performed	47.83%	□□
Medical Attention for Nephropathy	94.93%	□□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	65.12%	□□□□
Adult BMI Assessment		
Adult BMI Assessment	98.54%	□□□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	NA	NC
Medication Compliance 50%—Ages 12–18 Years[1]	NA	NC
Medication Compliance 50%—Ages 19–50 Years[1]	NA	NC
Medication Compliance 50%—Ages 51–64 Years[1]	NA	NC
Medication Compliance 50%—Total[1]	NA	NC
Medication Compliance 75%—Ages 5–11 Years	NA	NC
Medication Compliance 75%—Ages 12–18 Years	NA	NC
Medication Compliance 75%—Ages 19–50 Years	NA	NC
Medication Compliance 75%—Ages 51–64 Years	NA	NC
Medication Compliance 75%—Total	NA	NC
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	97.52%	□□□□□
Diuretics	95.69%	□□□□□
Total	96.86%	NC
Plan All-Cause Readmissions		

Positive-S Measures	RY 2018	2018 Performance Level
*18–44 Years**	23.96%	NC
*45–54 Years**	22.50%	NC
*55–64 Years**	26.09%	NC
*18–64 Years—Total**	24.03%	NC
*65–74 Years**	NA	NC
*75-84 Years**	NA	NC
*85+ Years**	NA	NC
*65+ Years—Total**	NA	NC
HIV Viral Load Suppression		
18–64 Years	84.15%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	NA	NC
Initiation of AOD Treatment—Total—18+ Years	31.91%	NC
Initiation of AOD Treatment—Total—Total	31.91%	NC
Engagement of AOD Treatment—Total—13–17 Years	NA	NC
Engagement of AOD Treatment—Total—18+ Years	4.26%	NC
Engagement of AOD Treatment—Total—Total	4.26%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	NA	NC
30-Day Follow-Up	NA	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	NA	NC
30-Day Follow-Up	NA	NC
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	NA	NC
7-Day Follow-Up—18+ Years	NA	NC
7-Day Follow-Up—Total	NA	NC
30-Day Follow-Up—13–17 Years	NA	NC
30-Day Follow-Up—18+ Years	NA	NC
30-Day Follow-Up—Total	NA	NC
Antidepressant Medication Management		
Effective Acute Phase Treatment	43.86%	□
Effective Continuation Phase Treatment	38.60%	□□□
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	42.00%	□

Positive-S Measures	RY 2018	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	NA	NC
Total	NA	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	NA	NC
*12–17 Years**	NA	NC
*Total**	NA	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	NA	NC
Total	NA	NC
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	34.31%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	98.44%	□□□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	NA	NC
25 Months–6 Years	NA	NC
7–11 Years	NA	NC
12–19 Years	NA	NC
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	88.98%	□□□□□
45–64 Years	93.94%	□□□□□
65 Years and Older	NA	NC
Total	92.43%	□□□□□
Call Answer Timeliness		
Call Answer Timeliness	85.48%	□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	495.00	NC
*ED Visits—Total**	164.97	□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	0.00	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	139.78	NC
*Multiple Pharmacies**	53.76	NC
*Multiple Prescribers and Multiple Pharmacies**	21.51	NC

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication

Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness, and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Prestige

Table D-12—RY 2018 Results—Prestige

Prestige Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	3.65%	□
One Well-Child Visit	2.19%	□□□
Two Well-Child Visits	3.65%	□□□
Three Well-Child Visits	7.06%	□□□□
Four Well-Child Visits	8.76%	□□
Five Well-Child Visits	10.46%	□
Six or More Well-Child Visits	64.23%	□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.70%	□□□
Childhood Immunization Status		
Combination 2	77.13%	□□□
Combination 3	72.02%	□□□
Lead Screening in Children		
Lead Screening in Children	63.99%	□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	50.65%	□□□
Continuation and Maintenance Phase	69.38%	□□□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	85.64%	□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	52.31%	□□□
Immunizations for Adolescents		
Combination 1	67.64%	□
Combination 2	32.12%	NC
Annual Dental Visit		
2–3 Years	29.37%	□
4–6 Years	52.01%	□
7–10 Years	61.50%	□□
11–14 Years	57.59%	□□
15–18 Years	55.19%	□□□
19–20 Years	39.96%	□□□
Total	52.34%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	0.00%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	58.15%	□□
Chlamydia Screening in Women		

Prestige Measures	RY 2018	2018 Performance Level
16–20 Years	58.97%	□□□
21–24 Years	67.58%	□□□
Total	61.56%	□□□
Breast Cancer Screening		
Breast Cancer Screening	57.07%	NC

Prestige Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	83.45%	□□
Postpartum Care	62.04%	□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	1.46%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	40.47%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	7.29%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	11.14%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	42.98%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.06%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	7.53%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	84.04%	□
*HbA1c Poor Control (>9.0%)**	50.46%	□
HbA1c Control (<8.0%)	42.25%	□□
Eye Exam (Retinal) Performed	42.10%	□
Medical Attention for Nephropathy	91.95%	□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	25.55%	□
Adult BMI Assessment		
Adult BMI Assessment	86.86%	□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	46.21%	□
Medication Compliance 50%—Ages 12–18 Years[1]	47.88%	□□
Medication Compliance 50%—Ages 19–50 Years[1]	62.75%	□□□
Medication Compliance 50%—Ages 51–64 Years[1]	84.73%	□□□□□
Medication Compliance 50%—Total[1]	51.20%	□
Medication Compliance 75%—Ages 5–11 Years	23.14%	□□
Medication Compliance 75%—Ages 12–18 Years	23.18%	□□
Medication Compliance 75%—Ages 19–50 Years	41.74%	□□□
Medication Compliance 75%—Ages 51–64 Years	62.60%	□□□□
Medication Compliance 75%—Total	28.04%	□□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	89.75%	□□□
Diuretics	89.73%	□□□
Total	89.74%	NC

Prestige Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	15.05%	NC
*45–54 Years**	19.22%	NC
*55–64 Years**	20.47%	NC
*18–64 Years—Total**	17.96%	NC
*65–74 Years**	8.16%	NC
*75-84 Years**	7.79%	NC
*85+ Years**	NA	NC
*65+ Years—Total**	7.77%	NC
HIV Viral Load Suppression		
18–64 Years	0.00%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	77.51%	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	78.03%	□□□
Discussing Cessation Medications—18–64 Years	50.59%	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	51.15%	□□□
Discussing Cessation Strategies—18–64 Years	43.79%	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	45.09%	□□□
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	26.33%	NC
Initiation of AOD Treatment—Total—18+ Years	36.23%	NC
Initiation of AOD Treatment—Total—Total	35.57%	NC
Engagement of AOD Treatment—Total—13–17 Years	11.39%	NC
Engagement of AOD Treatment—Total—18+ Years	7.70%	NC
Engagement of AOD Treatment—Total—Total	7.94%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	18.72%	NC
30-Day Follow-Up	40.00%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	24.18%	□
30-Day Follow-Up	45.85%	□□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	3.75%	□□
7-Day Follow-Up—18+ Years	7.11%	□
7-Day Follow-Up—Total	6.87%	□□
30-Day Follow-Up—13–17 Years	5.00%	□
30-Day Follow-Up—18+ Years	10.47%	□□
30-Day Follow-Up—Total	10.07%	□□
Antidepressant Medication Management		
Effective Acute Phase Treatment	53.56%	□□□

Prestige Measures	RY 2018	2018 Performance Level
Effective Continuation Phase Treatment	36.84%	□□□
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	57.98%	□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	35.53%	□□□□
12–17 Years	37.82%	□□□
Total	36.97%	□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	0.67%	□□□
*12–17 Years**	0.64%	□□□□
*Total**	0.65%	□□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	63.49%	□□□
12–17 Years	53.38%	□
Total	57.21%	□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	23.60%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.34%	□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	93.49%	□□
25 Months–6 Years	85.94%	□□
7–11 Years	86.08%	□
12–19 Years	81.63%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	68.25%	□
45–64 Years	84.45%	□□
65 Years and Older	84.53%	□□
Total	73.71%	□
Call Answer Timeliness		
Call Answer Timeliness	82.66%	□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	304.55	NC
*ED Visits—Total**	73.91	□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	114.50	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	217.18	NC

Prestige Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	162.36	NC
*Multiple Prescribers and Multiple Pharmacies**	79.81	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Simply

Table D-13—RY 2018 Results—Simply

Simply Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	1.46%	□□□
One Well-Child Visit	1.46%	□□
Two Well-Child Visits	1.95%	□
Three Well-Child Visits	4.38%	□□
Four Well-Child Visits	5.11%	□
Five Well-Child Visits	15.33%	□□
Six or More Well-Child Visits	70.32%	□□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	83.70%	□□□□□
Childhood Immunization Status		
Combination 2	72.99%	□□
Combination 3	66.42%	□□
Lead Screening in Children		
Lead Screening in Children	76.16%	□□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	41.30%	□□
Continuation and Maintenance Phase	53.06%	□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	80.54%	□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	65.45%	□□□□
Immunizations for Adolescents		
Combination 1	73.97%	□□
Combination 2	35.04%	NC
Annual Dental Visit		
2–3 Years	37.05%	□□
4–6 Years	58.37%	□□
7–10 Years	65.27%	□□
11–14 Years	59.08%	□□
15–18 Years	48.48%	□□
19–20 Years	31.32%	□□
Total	54.41%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	29.05%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	62.53%	□□□
Chlamydia Screening in Women		

Simply Measures	RY 2018	2018 Performance Level
16–20 Years	69.53%	□□□□
21–24 Years	65.71%	□□□
Total	68.87%	□□□□
Breast Cancer Screening		
Breast Cancer Screening	68.94%	NC

Simply Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	86.13%	□□□
Postpartum Care	70.32%	□□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	26.42%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	7.55%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	10.41%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	32.51%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.10%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	2.68%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	92.46%	□□□□
*HbA1c Poor Control (>9.0%)**	29.93%	□□□□
HbA1c Control (<8.0%)	57.42%	□□□□
Eye Exam (Retinal) Performed	52.07%	□□
Medical Attention for Nephropathy	97.57%	□□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	60.58%	□□□
Adult BMI Assessment		
Adult BMI Assessment	88.81%	□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	57.14%	□□□
Medication Compliance 50%—Ages 12–18 Years[1]	49.64%	□□
Medication Compliance 50%—Ages 19–50 Years[1]	73.75%	□□□□
Medication Compliance 50%—Ages 51–64 Years[1]	83.05%	□□□□
Medication Compliance 50%—Total[1]	62.93%	□□□
Medication Compliance 75%—Ages 5–11 Years	25.71%	□□
Medication Compliance 75%—Ages 12–18 Years	18.25%	□
Medication Compliance 75%—Ages 19–50 Years	40.00%	□□□
Medication Compliance 75%—Ages 51–64 Years	56.78%	□□□□
Medication Compliance 75%—Total	32.24%	□□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	94.84%	□□□□□
Diuretics	95.06%	□□□□□
Total	94.92%	NC

Simply Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	18.53%	NC
*45–54 Years**	22.38%	NC
*55–64 Years**	24.00%	NC
*18–64 Years—Total**	22.06%	NC
*65–74 Years**	16.16%	NC
*75-84 Years**	13.70%	NC
*85+ Years**	5.88%	NC
*65+ Years—Total**	14.03%	NC
HIV Viral Load Suppression		
18–64 Years	0.00%	NC
65+ Years	0.00%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	87.16%	□□□□□
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	60.19%	□□□□
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	58.33%	□□□□□
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	27.78%	NC
Initiation of AOD Treatment—Total—18+ Years	17.79%	NC
Initiation of AOD Treatment—Total—Total	18.22%	NC
Engagement of AOD Treatment—Total—13–17 Years	9.26%	NC
Engagement of AOD Treatment—Total—18+ Years	1.83%	NC
Engagement of AOD Treatment—Total—Total	2.15%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	24.63%	NC
30-Day Follow-Up	40.32%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	27.41%	□
30-Day Follow-Up	44.67%	□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	NA	NC
7-Day Follow-Up—18+ Years	22.58%	□□□□
7-Day Follow-Up—Total	18.92%	□□□□
30-Day Follow-Up—13–17 Years	NA	NC
30-Day Follow-Up—18+ Years	23.66%	□□□
30-Day Follow-Up—Total	19.82%	□□□
Antidepressant Medication Management		
Effective Acute Phase Treatment	61.17%	□□□□
Effective Continuation Phase Treatment	47.56%	□□□□

Simply Measures	RY 2018	2018 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	62.19%	□□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	51.52%	□□□□□
12–17 Years	64.76%	□□□□□
Total	61.87%	□□□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	NA	NC
*12–17 Years**	0.00%	□□□□□
*Total**	0.00%	□□□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	NA	NC
12–17 Years	44.64%	□
Total	48.65%	□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	34.53%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.67%	□□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	95.67%	□□
25 Months–6 Years	91.00%	□□□□
7–11 Years	91.37%	□□□
12–19 Years	85.58%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	70.11%	□
45–64 Years	89.56%	□□□□
65 Years and Older	92.97%	□□□□
Total	83.53%	□□□
Call Answer Timeliness		
Call Answer Timeliness	94.57%	□□□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	379.41	NC
*ED Visits—Total**	53.39	□□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	149.29	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	719.75	NC

Simply Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	719.75	NC
*Multiple Prescribers and Multiple Pharmacies**	719.75	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Staywell

Table D-14—RY 2018 Results—Staywell

Staywell Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	1.32%	□□□
One Well-Child Visit	1.84%	□□□
Two Well-Child Visits	3.68%	□□□
Three Well-Child Visits	4.74%	□□
Four Well-Child Visits	10.00%	□□□
Five Well-Child Visits	11.32%	□
Six or More Well-Child Visits	67.11%	□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.70%	□□□
Childhood Immunization Status		
Combination 2	78.35%	□□□
Combination 3	72.51%	□□□
Lead Screening in Children		
Lead Screening in Children	64.58%	□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	56.69%	□□□□
Continuation and Maintenance Phase	71.10%	□□□□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	70.88%	□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	59.46%	□□□
Immunizations for Adolescents		
Combination 1	70.80%	□□
Combination 2	27.98%	NC
Annual Dental Visit		
2–3 Years	30.54%	□□
4–6 Years	53.34%	□□
7–10 Years	60.82%	□□
11–14 Years	55.29%	□□
15–18 Years	47.74%	□□
19–20 Years	29.70%	□□
Total	50.86%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	55.31%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	59.38%	□□□
Chlamydia Screening in Women		

Staywell Measures	RY 2018	2018 Performance Level
16–20 Years	60.95%	□□□□
21–24 Years	70.41%	□□□□
Total	63.33%	□□□
Breast Cancer Screening		
Breast Cancer Screening	53.80%	NC

Staywell Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	82.78%	□□
Postpartum Care	66.94%	□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	1.16%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	37.45%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	8.21%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	12.65%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	43.14%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.04%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	7.95%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	84.52%	□□
*HbA1c Poor Control (>9.0%)**	40.54%	□□□
HbA1c Control (<8.0%)	51.60%	□□□
Eye Exam (Retinal) Performed	57.25%	□□□
Medical Attention for Nephropathy	92.14%	□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	58.72%	□□□
Adult BMI Assessment		
Adult BMI Assessment	89.29%	□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	55.59%	□□□
Medication Compliance 50%—Ages 12–18 Years[1]	54.25%	□□□
Medication Compliance 50%—Ages 19–50 Years[1]	63.59%	□□□
Medication Compliance 50%—Ages 51–64 Years[1]	76.61%	□□□
Medication Compliance 50%—Total[1]	56.98%	□□
Medication Compliance 75%—Ages 5–11 Years	28.35%	□□□
Medication Compliance 75%—Ages 12–18 Years	26.14%	□□
Medication Compliance 75%—Ages 19–50 Years	37.08%	□□
Medication Compliance 75%—Ages 51–64 Years	52.88%	□□□
Medication Compliance 75%—Total	29.71%	□□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	91.92%	□□□□
Diuretics	92.09%	□□□□
Total	91.99%	NC

Staywell Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	20.83%	NC
*45–54 Years**	24.09%	NC
*55–64 Years**	22.88%	NC
*18–64 Years—Total**	22.18%	NC
*65–74 Years**	17.81%	NC
*75-84 Years**	16.45%	NC
*85+ Years**	12.88%	NC
*65+ Years—Total**	16.86%	NC
HIV Viral Load Suppression		
18–64 Years	0.20%	NC
65+ Years	0.00%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	46.48%	NC
Initiation of AOD Treatment—Total—18+ Years	43.13%	NC
Initiation of AOD Treatment—Total—Total	43.45%	NC
Engagement of AOD Treatment—Total—13–17 Years	13.66%	NC
Engagement of AOD Treatment—Total—18+ Years	8.13%	NC
Engagement of AOD Treatment—Total—Total	8.68%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	31.04%	NC
30-Day Follow-Up	52.73%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	30.56%	□□
30-Day Follow-Up	47.68%	□□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	0.92%	□
7-Day Follow-Up—18+ Years	4.08%	□
7-Day Follow-Up—Total	3.65%	□
30-Day Follow-Up—13–17 Years	1.38%	□
30-Day Follow-Up—18+ Years	6.78%	□
30-Day Follow-Up—Total	6.04%	□
Antidepressant Medication Management		
Effective Acute Phase Treatment	50.19%	□□
Effective Continuation Phase Treatment	34.23%	□□

Staywell Measures	RY 2018	2018 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.32%	□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	28.93%	□□□
12–17 Years	39.09%	□□□
Total	35.12%	□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	1.69%	□□
*12–17 Years**	2.02%	□□□
*Total**	1.88%	□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	66.46%	□□□
12–17 Years	60.59%	□□
Total	62.70%	□□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	21.49%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.68%	□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	95.71%	□□□
25 Months–6 Years	88.80%	□□□
7–11 Years	89.49%	□□
12–19 Years	86.55%	□□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	71.02%	□
45–64 Years	87.56%	□□□
65 Years and Older	91.58%	□□□□
Total	77.13%	□□
Call Answer Timeliness		
Call Answer Timeliness	90.10%	□□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	346.46	NC
*ED Visits—Total**	72.11	□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	75.54	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	220.11	NC

Staywell Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	73.94	NC
*Multiple Prescribers and Multiple Pharmacies**	44.60	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Sunshine

Table D-15—RY 2018 Results—Sunshine

Sunshine Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	2.92%	□□
One Well-Child Visit	2.43%	□□□
Two Well-Child Visits	1.95%	□
Three Well-Child Visits	4.14%	□□
Four Well-Child Visits	8.03%	□□
Five Well-Child Visits	13.14%	□
Six or More Well-Child Visits	67.40%	□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.16%	□□□
Childhood Immunization Status		
Combination 2	77.37%	□□□
Combination 3	75.18%	□□□
Lead Screening in Children		
Lead Screening in Children	66.40%	□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	46.79%	□□□
Continuation and Maintenance Phase	64.46%	□□□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	86.37%	□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	51.58%	□□□
Immunizations for Adolescents		
Combination 1	71.29%	□□
Combination 2	26.52%	NC
Annual Dental Visit		
2–3 Years	30.51%	□□
4–6 Years	50.61%	□
7–10 Years	57.99%	□
11–14 Years	50.96%	□
15–18 Years	43.04%	□
19–20 Years	25.32%	□
Total	47.52%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	27.89%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	58.39%	□□□
Chlamydia Screening in Women		

Sunshine Measures	RY 2018	2018 Performance Level
16–20 Years	61.61%	□□□□
21–24 Years	70.01%	□□□□
Total	64.23%	□□□□
Breast Cancer Screening		
Breast Cancer Screening	58.50%	NC

Sunshine Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	79.56%	□□
Postpartum Care	60.10%	□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	0.85%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	33.88%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	7.61%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	9.76%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	37.37%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.05%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	7.02%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	85.40%	□□
*HbA1c Poor Control (>9.0%)**	45.01%	□□
HbA1c Control (<8.0%)	47.45%	□□
Eye Exam (Retinal) Performed	60.83%	□□□
Medical Attention for Nephropathy	93.43%	□□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	37.71%	□
Adult BMI Assessment		
Adult BMI Assessment	87.35%	□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	50.60%	□□
Medication Compliance 50%—Ages 12–18 Years[1]	47.75%	□□
Medication Compliance 50%—Ages 19–50 Years[1]	55.83%	□
Medication Compliance 50%—Ages 51–64 Years[1]	72.34%	□□
Medication Compliance 50%—Total[1]	51.33%	□
Medication Compliance 75%—Ages 5–11 Years	24.24%	□□
Medication Compliance 75%—Ages 12–18 Years	20.59%	□
Medication Compliance 75%—Ages 19–50 Years	29.54%	□
Medication Compliance 75%—Ages 51–64 Years	51.06%	□□
Medication Compliance 75%—Total	24.98%	□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	92.13%	□□□□
Diuretics	92.20%	□□□□
Total	92.16%	NC

Sunshine Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	21.32%	NC
*45–54 Years**	26.36%	NC
*55–64 Years**	24.28%	NC
*18–64 Years—Total**	23.29%	NC
*65–74 Years**	21.17%	NC
*75-84 Years**	14.20%	NC
*85+ Years**	11.76%	NC
*65+ Years—Total**	17.65%	NC
HIV Viral Load Suppression		
18–64 Years	7.30%	NC
65+ Years	NA	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	78.38%	□□□
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	61.82%	□□□□□
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	49.54%	□□□□
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	45.27%	NC
Initiation of AOD Treatment—Total—18+ Years	46.93%	NC
Initiation of AOD Treatment—Total—Total	46.78%	NC
Engagement of AOD Treatment—Total—13–17 Years	14.08%	NC
Engagement of AOD Treatment—Total—18+ Years	7.24%	NC
Engagement of AOD Treatment—Total—Total	7.87%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	32.66%	NC
30-Day Follow-Up	52.78%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	24.33%	□
30-Day Follow-Up	40.19%	□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	1.64%	□
7-Day Follow-Up—18+ Years	4.94%	□
7-Day Follow-Up—Total	4.54%	□
30-Day Follow-Up—13–17 Years	3.28%	□
30-Day Follow-Up—18+ Years	7.52%	□
30-Day Follow-Up—Total	7.01%	□
Antidepressant Medication Management		
Effective Acute Phase Treatment	50.59%	□□

Sunshine Measures	RY 2018	2018 Performance Level
Effective Continuation Phase Treatment	35.84%	□□
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.16%	□□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	32.01%	□□□
12–17 Years	41.43%	□□□□
Total	37.86%	□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	0.52%	□□□□
*12–17 Years**	1.35%	□□□□
*Total**	1.02%	□□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	69.06%	□□□
12–17 Years	55.60%	□
Total	60.65%	□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	38.85%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.27%	□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	93.11%	□
25 Months–6 Years	85.16%	□□
7–11 Years	84.88%	□
12–19 Years	80.07%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	63.20%	□
45–64 Years	80.78%	□
65 Years and Older	82.17%	□□
Total	68.87%	□
Call Answer Timeliness		
Call Answer Timeliness	82.50%	□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	282.03	NC
*ED Visits—Total**	66.71	□□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	103.91	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	215.44	NC

Sunshine Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	70.36	NC
*Multiple Prescribers and Multiple Pharmacies**	42.59	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Sunshine–S

Table D-16—RY 2018 Results—Sunshine–S

Sunshine-S Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	0.97%	□□□□
One Well-Child Visit	0.49%	□
Two Well-Child Visits	2.19%	□
Three Well-Child Visits	3.16%	□
Four Well-Child Visits	8.76%	□□
Five Well-Child Visits	20.68%	□□□□
Six or More Well-Child Visits	63.75%	□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	85.16%	□□□□□
Childhood Immunization Status		
Combination 2	83.45%	□□□□□
Combination 3	77.62%	□□□□
Lead Screening in Children		
Lead Screening in Children	72.85%	□□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	51.67%	□□□
Continuation and Maintenance Phase	61.54%	□□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	90.27%	□□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	64.96%	□□□□
Immunizations for Adolescents		
Combination 1	68.86%	□□
Combination 2	29.68%	NC
Annual Dental Visit		
2–3 Years	47.85%	□□□□
4–6 Years	73.48%	□□□□
7–10 Years	71.65%	□□□
11–14 Years	61.57%	□□
15–18 Years	59.16%	□□□□
19–20 Years	29.63%	□□
Total	63.79%	□□□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	31.95%	NC
Women's Care		
Chlamydia Screening in Women		
16–20 Years	70.08%	□□□□□
21–24 Years	NA	NC

Sunshine-S Measures	RY 2018	2018 Performance Level
Total	70.08%	□□□□
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	60.91%	□
Postpartum Care	48.18%	□

Sunshine-S Measures	RY 2018	2018 Performance Level
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	2.08%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	26.04%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	5.21%	NC
Living With Illness		
Adult BMI Assessment		
Adult BMI Assessment	NA	NC
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	62.09%	□□□□
Medication Compliance 50%—Ages 12–18 Years[1]	63.21%	□□□□
Medication Compliance 50%—Ages 19–50 Years[1]	NA	NC
Medication Compliance 50%—Ages 51–64 Years[1]	NA	NC
Medication Compliance 50%—Total[1]	62.50%	□□□
Medication Compliance 75%—Ages 5–11 Years	32.97%	□□□
Medication Compliance 75%—Ages 12–18 Years	34.91%	□□□□
Medication Compliance 75%—Ages 19–50 Years	NA	NC
Medication Compliance 75%—Ages 51–64 Years	NA	NC
Medication Compliance 75%—Total	33.68%	□□□
HIV Viral Load Suppression		
18–64 Years	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	48.48%	NC
Initiation of AOD Treatment—Total—18+ Years	43.66%	NC
Initiation of AOD Treatment—Total—Total	47.21%	NC
Engagement of AOD Treatment—Total—13–17 Years	12.37%	NC
Engagement of AOD Treatment—Total—18+ Years	11.27%	NC
Engagement of AOD Treatment—Total—Total	12.08%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	44.80%	NC
30-Day Follow-Up	71.53%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	52.44%	□□□□
30-Day Follow-Up	77.44%	□□□□□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	0.00%	□
7-Day Follow-Up—18+ Years	NA	NC
7-Day Follow-Up—Total	0.00%	□
30-Day Follow-Up—13–17 Years	4.76%	□
30-Day Follow-Up—18+ Years	NA	NC
30-Day Follow-Up—Total	4.96%	□

Sunshine-S Measures	RY 2018	2018 Performance Level
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	40.45%	□□□□
12–17 Years	52.04%	□□□□□
Total	48.23%	□□□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	0.00%	□□□□□
*12–17 Years**	1.80%	□□□
*Total**	1.19%	□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	77.49%	□□□□□
12–17 Years	72.66%	□□□□
Total	74.74%	□□□□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	73.88%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.63%	□□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	97.70%	□□□□
25 Months–6 Years	91.26%	□□□□
7–11 Years	85.60%	□
12–19 Years	81.35%	□
Call Answer Timeliness		
Call Answer Timeliness	79.71%	□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	297.57	NC
*ED Visits—Total**	53.45	□□□

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*
□□□□ *= 75th to 89th percentile*
□□□ *= 50th to 74th percentile*
□□ *= 25th to 49th percentile*
□ *= Below 25th percentile*

United

Table D-17—RY 2018 Results—United

United Measures	RY 2018	2018 Performance Level
Pediatric Care		
Well-Child Visits in the First 15 Months of Life		
*No Well-Child Visits**	2.43%	□□
One Well-Child Visit	1.22%	□□
Two Well-Child Visits	2.43%	□□
Three Well-Child Visits	4.38%	□□
Four Well-Child Visits	4.62%	□
Five Well-Child Visits	12.41%	□
Six or More Well-Child Visits	72.51%	□□□□□
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.86%	□□□
Childhood Immunization Status		
Combination 2	78.83%	□□□
Combination 3	73.97%	□□□
Lead Screening in Children		
Lead Screening in Children	67.64%	□□
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	47.28%	□□□
Continuation and Maintenance Phase	64.44%	□□□□
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	87.59%	□□□□□
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	55.96%	□□□
Immunizations for Adolescents		
Combination 1	71.05%	□□
Combination 2	28.95%	NC
Annual Dental Visit		
2–3 Years	29.72%	□□
4–6 Years	49.98%	□
7–10 Years	57.67%	□
11–14 Years	51.85%	□
15–18 Years	45.35%	□□
19–20 Years	28.59%	□□
Total	47.48%	□□
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk		
Dental Sealants for Children Ages 6 to 9 Years at Elevated Caries Risk	27.19%	NC
Women's Care		
Cervical Cancer Screening		
Cervical Cancer Screening	63.02%	□□□
Chlamydia Screening in Women		

United Measures	RY 2018	2018 Performance Level
16–20 Years	61.79%	□□□□
21–24 Years	69.75%	□□□□
Total	64.12%	□□□□
Breast Cancer Screening		
Breast Cancer Screening	62.25%	NC

United Measures	RY 2018	2018 Performance Level
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	81.75%	□□
Postpartum Care	65.45%	□□□
Contraceptive Care—Postpartum Women		
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	1.49%	NC
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	35.82%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	8.96%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	4.47%	NC
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	29.20%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	0.00%	NC
Ages 21–44 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	8.17%	NC
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	87.10%	□□□
*HbA1c Poor Control (>9.0%)**	41.61%	□□
HbA1c Control (<8.0%)	49.64%	□□□
Eye Exam (Retinal) Performed	50.85%	□□
Medical Attention for Nephropathy	93.19%	□□□□
Controlling High Blood Pressure		
Controlling High Blood Pressure	55.72%	□□
Adult BMI Assessment		
Adult BMI Assessment	88.81%	□□□
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years[1]	51.53%	□□
Medication Compliance 50%—Ages 12–18 Years[1]	46.23%	□
Medication Compliance 50%—Ages 19–50 Years[1]	70.65%	□□□□
Medication Compliance 50%—Ages 51–64 Years[1]	73.85%	□□□
Medication Compliance 50%—Total[1]	54.66%	□□
Medication Compliance 75%—Ages 5–11 Years	26.45%	□□
Medication Compliance 75%—Ages 12–18 Years	22.64%	□□
Medication Compliance 75%—Ages 19–50 Years	42.26%	□□□
Medication Compliance 75%—Ages 51–64 Years	58.46%	□□□□
Medication Compliance 75%—Total	30.12%	□□
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	92.87%	□□□□□
Diuretics	92.94%	□□□□□
Total	92.90%	NC

United Measures	RY 2018	2018 Performance Level
Plan All-Cause Readmissions		
*18–44 Years**	20.90%	NC
*45–54 Years**	20.10%	NC
*55–64 Years**	20.18%	NC
*18–64 Years—Total**	20.52%	NC
*65–74 Years**	8.14%	NC
*75-84 Years**	5.15%	NC
*85+ Years**	0.47%	NC
*65+ Years—Total**	4.65%	NC
HIV Viral Load Suppression		
18–64 Years	51.13%	NC
65+ Years	22.47%	NC
Medical Assistance With Smoking and Tobacco Use Cessation		
Advising Smokers and Tobacco Users to Quit—18–64 Years	NA	NC
Advising Smokers and Tobacco Users to Quit—65+ Years	NA	NC
Advising Smokers and Tobacco Users to Quit—Total	NA	NC
Discussing Cessation Medications—18–64 Years	NA	NC
Discussing Cessation Medications—65+ Years	NA	NC
Discussing Cessation Medications—Total	NA	NC
Discussing Cessation Strategies—18–64 Years	NA	NC
Discussing Cessation Strategies—65+ Years	NA	NC
Discussing Cessation Strategies—Total	NA	NC
Behavioral Health		
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total—13–17 Years	47.03%	NC
Initiation of AOD Treatment—Total—18+ Years	41.10%	NC
Initiation of AOD Treatment—Total—Total	41.45%	NC
Engagement of AOD Treatment—Total—13–17 Years	11.86%	NC
Engagement of AOD Treatment—Total—18+ Years	5.36%	NC
Engagement of AOD Treatment—Total—Total	5.75%	NC
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	29.50%	NC
30-Day Follow-Up	50.62%	NC
Follow-Up After ED Visit for Mental Illness[1]		
7-Day Follow-Up	22.39%	□
30-Day Follow-Up	38.62%	□
Follow-Up After ED Visit for AOD Abuse or Dependence[1]		
7-Day Follow-Up—13–17 Years	1.32%	□
7-Day Follow-Up—18+ Years	3.63%	□
7-Day Follow-Up—Total	3.37%	□
30-Day Follow-Up—13–17 Years	1.32%	□
30-Day Follow-Up—18+ Years	5.78%	□
30-Day Follow-Up—Total	5.28%	□
Antidepressant Medication Management		
Effective Acute Phase Treatment	51.35%	□□
Effective Continuation Phase Treatment	35.37%	□□

United Measures	RY 2018	2018 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.93%	□□□
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	32.68%	□□□
12–17 Years	40.16%	□□□
Total	37.27%	□□□
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
*1–5 Years**	NA	NC
*6–11 Years**	0.38%	□□□□
*12–17 Years**	1.59%	□□□
*Total**	1.12%	□□□□
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
1–5 Years	NA	NC
6–11 Years	65.22%	□□□
12–17 Years	56.97%	□□
Total	60.08%	□□
Mental Health Readmission Rate		
*Mental Health Readmission Rate**	25.38%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.40%	□□
Access/Availability of Care		
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	95.21%	□□
25 Months–6 Years	88.32%	□□□
7–11 Years	88.05%	□□
12–19 Years	84.85%	□
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	72.27%	□
45–64 Years	86.80%	□□
65 Years and Older	90.18%	□□□
Total	77.93%	□□
Call Answer Timeliness		
Call Answer Timeliness	93.69%	□□□□□
Use of Services		
Ambulatory Care (per 1,000 Member Months)		
Outpatient Visits—Total	319.44	NC
*ED Visits—Total**	73.85	□
Use of Opioids at High Dosage		
*Use of Opioids at High Dosage**	64.26	NC
Use of Opioids From Multiple Providers		
*Multiple Prescribers**	241.46	NC

United Measures	RY 2018	2018 Performance Level
*Multiple Pharmacies**	39.70	NC
*Multiple Prescribers and Multiple Pharmacies**	27.70	NC

[1]*2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Medication Management for People With Asthma—Medication Compliance 50%—Total, Follow-Up After ED Visit for Mental Illness,* and *Follow-Up After ED Visit for AOD Abuse or Dependence measure indicator rates, which were compared to national Medicaid NCQA Audit Means and Percentiles HEDIS 2017 benchmarks.*
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the MMA plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Appendix E. LTC Plan-Specific Results

Appendix E includes the RY 2018 results for the LTC plans.

Aetna Better Health–LTC

Table E-1—RY 2018 Results—Aetna Better Health–LTC

Aetna Better Health-LTC Measures	RY 2018	2018 Performance Level
LTC		
Care for Older Adults		
Advance Care Planning—18–60 Years	80.00%	NC
Advance Care Planning—61–65 Years	80.00%	NC
Advance Care Planning—66+ Years	84.66%	NC
Advance Care Planning—Total	83.78%	NC
Medication Review—18–60 Years	98.28%	NC
Medication Review—61–65 Years	100.00%	NC
Medication Review—66+ Years	97.23%	NC
Medication Review—Total	97.78%	NC
Functional Status Assessment—18–60 Years	84.38%	NC
Functional Status Assessment—61–65 Years	87.50%	NC
Functional Status Assessment—66+ Years	93.22%	NC
Functional Status Assessment—Total	91.56%	NC
Call Answer Timeliness[1]		
Call Answer Timeliness	94.06%	□□□□□
Required Record Documentation		
701B Assessment	92.89%	NC
Plan of Care—Enrollee Participation	99.33%	NC
Plan of Care—PCP Notification	80.89%	NC
Freedom of Choice Form	95.78%	NC
*Plan of Care—LTC Service Authorizations**	0.00%	NC
Face-to-Face Encounters		
Face-to-Face Encounters	86.56%	NC
Case Manager Training		
Case Manager Training	94.17%	NC
Timeliness of Service		
Timeliness of Service	95.32%	NC

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Call Answer Timeliness measure rate, which was compared to Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015 (the most recent year available).

** For this indicator, a lower rate indicates better performance.*

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.

2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Amerigroup–LTC

Table E-2—RY 2018 Results—Amerigroup–LTC

Amerigroup-LTC Measures	RY 2018	2018 Performance Level
LTC		
Care for Older Adults		
Advance Care Planning—18–60 Years	100.00%	NC
Advance Care Planning—61–65 Years	NA	NC
Advance Care Planning—66+ Years	95.73%	NC
Advance Care Planning—Total	96.11%	NC
Medication Review—18–60 Years	95.35%	NC
Medication Review—61–65 Years	NA	NC
Medication Review—66+ Years	NA	NC
Medication Review—Total	95.89%	NC
Functional Status Assessment—18–60 Years	92.50%	NC
Functional Status Assessment—61–65 Years	NA	NC
Functional Status Assessment—66+ Years	97.73%	NC
Functional Status Assessment—Total	97.32%	NC
Call Answer Timeliness[1]		
Call Answer Timeliness	48.33%	□
Required Record Documentation		
701B Assessment	90.27%	NC
Plan of Care—Enrollee Participation	82.48%	NC
Plan of Care—PCP Notification	90.75%	NC
Freedom of Choice Form	91.73%	NC
*Plan of Care—LTC Service Authorizations**	0.00%	NC
Face-to-Face Encounters		
Face-to-Face Encounters	75.94%	NC
Case Manager Training		
Case Manager Training	93.75%	NC
Timeliness of Service		
Timeliness of Service	93.30%	NC

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Call Answer Timeliness measure rate, which was compared to Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015 (the most recent year available).
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the LTC plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*
□□□□ *= 75th to 89th percentile*
□□□ *= 50th to 74th percentile*
□□ *= 25th to 49th percentile*
□ *= Below 25th percentile*

Humana–LTC

Table E-3—RY 2018 Results—Humana–LTC

Humana-LTC Measures	RY 2018	2018 Performance Level
LTC		
Care For Older Adults		
Advance Care Planning—18–60 Years	93.60%	NC
Advance Care Planning—61–65 Years	94.29%	NC
Advance Care Planning—66+ Years	92.47%	NC
Advance Care Planning—Total	92.71%	NC
Medication Review—18–60 Years	99.09%	NC
Medication Review—61–65 Years	100.00%	NC
Medication Review—66+ Years	100.00%	NC
Medication Review—Total	99.53%	NC
Functional Status Assessment—18–60 Years	89.65%	NC
Functional Status Assessment—61–65 Years	91.78%	NC
Functional Status Assessment—66+ Years	89.22%	NC
Functional Status Assessment—Total	89.40%	NC
Call Answer Timeliness[1]		
Call Answer Timeliness	98.52%	□□□□□
Required Record Documentation		
701B Assessment	92.86%	NC
Plan of Care—Enrollee Participation	89.05%	NC
Plan of Care—PCP Notification	83.81%	NC
Freedom of Choice Form	98.81%	NC
*Plan of Care—LTC Service Authorizations**	1.19%	NC
Face-to-Face Encounters		
Face-to-Face Encounters	91.09%	NC
Case Manager Training		
Case Manager Training	93.79%	NC
Timeliness of Service		
Timeliness of Service	90.79%	NC

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Call Answer Timeliness measure rate, which was compared to Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015 (the most recent year available).
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Molina–LTC

Table E-4—RY 2018 Results—Molina–LTC

Molina-LTC Measures	RY 2018	2018 Performance Level
LTC		
Care For Older Adults		
Advance Care Planning—18–60 Years	97.37%	NC
Advance Care Planning—61–65 Years	NA	NC
Advance Care Planning—66+ Years	98.86%	NC
Advance Care Planning—Total	98.78%	NC
Medication Review—18–60 Years	71.59%	NC
Medication Review—61–65 Years	NA	NC
Medication Review—66+ Years	43.53%	NC
Medication Review—Total	59.00%	NC
Functional Status Assessment—18–60 Years	100.00%	NC
Functional Status Assessment—61–65 Years	NA	NC
Functional Status Assessment—66+ Years	98.34%	NC
Functional Status Assessment—Total	98.54%	NC
Call Answer Timeliness[1]		
Call Answer Timeliness	97.68%	□□□□□
Required Record Documentation		
701B Assessment	96.35%	NC
Plan of Care—Enrollee Participation	92.21%	NC
Plan of Care—PCP Notification	97.08%	NC
Freedom of Choice Form	90.27%	NC
*Plan of Care—LTC Service Authorizations**	0.24%	NC
Face-to-Face Encounters		
Face-to-Face Encounters	87.82%	NC
Case Manager Training		
Case Manager Training	100.00%	NC
Timeliness of Service		
Timeliness of Service	88.81%	NC

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Call Answer Timeliness measure rate, which was compared to Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015 (the most recent year available).
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the LTC plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*
□□□□ *= 75th to 89th percentile*
□□□ *= 50th to 74th percentile*
□□ *= 25th to 49th percentile*
□ *= Below 25th percentile*

Sunshine–LTC

Table E-5—RY 2018 Results—Sunshine–LTC

Sunshine-LTC Measures	RY 2018	2018 Performance Level
LTC		
Care for Older Adults		
Advance Care Planning—18–60 Years	95.95%	NC
Advance Care Planning—61–65 Years	97.58%	NC
Advance Care Planning—66+ Years	96.97%	NC
Advance Care Planning—Total	96.88%	NC
Medication Review—18–60 Years	93.98%	NC
Medication Review—61–65 Years	95.56%	NC
Medication Review—66+ Years	91.26%	NC
Medication Review—Total	94.06%	NC
Functional Status Assessment—18–60 Years	96.33%	NC
Functional Status Assessment—61–65 Years	96.38%	NC
Functional Status Assessment—66+ Years	96.46%	NC
Functional Status Assessment—Total	96.43%	NC
Call Answer Timeliness[1]		
Call Answer Timeliness	73.62%	□
Required Record Documentation		
701B Assessment	97.32%	NC
Plan of Care—Enrollee Participation	69.59%	NC
Plan of Care—PCP Notification	54.01%	NC
Freedom of Choice Form	79.08%	NC
*Plan of Care—LTC Service Authorizations**	1.22%	NC
Face-to-Face Encounters		
Face-to-Face Encounters	94.86%	NC
Case Manager Training		
Case Manager Training	98.18%	NC
Timeliness of Service		
Timeliness of Service	94.54%	NC

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Call Answer Timeliness measure rate, which was compared to Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015 (the most recent year available).
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*
□□□□ *= 75th to 89th percentile*
□□□ *= 50th to 74th percentile*
□□ *= 25th to 49th percentile*
□ *= Below 25th percentile*

United–LTC

Table E-6—RY 2018 Results—United–LTC

United-LTC Measures	RY 2018	2018 Performance Level
LTC		
Care For Older Adults		
Advance Care Planning—18–60 Years	85.19%	NC
Advance Care Planning—61–65 Years	82.05%	NC
Advance Care Planning—66+ Years	89.94%	NC
Advance Care Planning—Total	88.56%	NC
Medication Review—18–60 Years	17.81%	NC
Medication Review—61–65 Years	26.67%	NC
Medication Review—66+ Years	26.95%	NC
Medication Review—Total	25.30%	NC
Functional Status Assessment—18–60 Years	93.44%	NC
Functional Status Assessment—61–65 Years	70.59%	NC
Functional Status Assessment—66+ Years	94.62%	NC
Functional Status Assessment—Total	92.46%	NC
Call Answer Timeliness[1]		
Call Answer Timeliness	94.15%	□□□□□
Required Record Documentation		
701B Assessment	81.51%	NC
Plan of Care—Enrollee Participation	48.66%	NC
Plan of Care—PCP Notification	55.72%	NC
Freedom of Choice Form	42.34%	NC
*Plan of Care—LTC Service Authorizations**	0.97%	NC
Face-to-Face Encounters		
Face-to-Face Encounters	55.67%	NC
Case Manager Training		
Case Manager Training	98.34%	NC
Timeliness of Service		
Timeliness of Service	44.86%	NC

[1]2018 performance levels were based on comparisons of the HEDIS 2018 measure indicator rates to national Medicaid Quality Compass HEDIS 2017 benchmarks, with the exception of the Call Answer Timeliness measure rate, which was compared to Quality Compass national Medicaid All Lines of Business percentiles for HEDIS 2015 (the most recent year available).
** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
2018 performance levels represent the following percentile comparisons:

□□□□□ *= 90th percentile and above*

□□□□ *= 75th to 89th percentile*

□□□ *= 50th to 74th percentile*

□□ *= 25th to 49th percentile*

□ *= Below 25th percentile*

Attachment VII

Florida's Managed Medical Assistance (MMA) Program Demonstration Waiver Evaluation: Design Update 2017-2022

Presented to: Centers for Medicare and Medicaid Services

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A. General Background Information

1. Issues Addressed by This Demonstration

Under the MMA demonstration, Florida seeks to continue building upon the following objectives that have been fundamental to Florida's Medicaid improvement efforts over the past 15 years:

- Improving outcomes through care coordination, patient engagement in their own health care, and maintaining fiscal responsibility. The demonstration seeks to improve care for Medicaid beneficiaries by providing care through nationally accredited managed care plans with broad networks, expansive benefits packages, top-quality scores, and high rate of customer satisfaction. The state will provide oversight focused on improving access and increasing quality of care.
- Improving program performance, particularly improved scores on nationally recognized quality measures (such as Healthcare Effectiveness Data and Information Set [HEDIS] scores), through expanding key components of the Medicaid managed care program statewide and competitively procuring plans on a regional basis to stabilize plan participation and enhance continuity of care. A key objective of improved program performance is to increase patient satisfaction.
- Improving access to coordinated care, continuity of care, and continuity of coverage by enrolling all Medicaid enrollees in managed care in a timely manner, except those specifically exempted. Increasing access to, stabilizing, and strengthening providers that serve uninsured, low- income populations in the state by targeting LIP funding to reimburse uncompensated care costs for services provided to low-income uninsured patients at hospitals and federally qualified health care centers (FQHC) and rural health clinics (RHC) that are furnished through charity care programs that adhere to the Healthcare Financial Management Association (HFMA) principles.[32] Improving continuity of coverage and care and encouraging uptake of preventive services, or encouraging individuals to obtain health coverage as soon as possible after becoming eligible, as applicable, as well as promoting the fiscal sustainability of the Medicaid program, through the waiver of retroactive eligibility.
- Improving integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

Florida's motivation for improving its Medicaid program stems from two factors: (1) the nationwide concerns about ensuring continued access to high quality care for its Medicaid enrollees while (2) simultaneously addressing the rapid increases in Medicaid costs that have propelled the Medicaid program to the very top of states' budget priorities nationwide.

2. Name of the Demonstration, Approval Date, and Time Period

Managed Medical Assistance 1115 Waiver Demonstration Extension, Project No. 11-W-00206/4, August 3, 2017 through June 30, 2022.

[32] Healthcare Financial Management Association, "Valuation and Financial Statement Presentation of Charity Care and Bad Debts by Institutional Healthcare Providers," Principles and Practices Board Statement 15, December 2012. http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589 , accessed on 11/27/17

Description of the Demonstration and History of the Implementation

The Centers for Medicare and Medicaid Services (Federal CMS) initially approved Florida's 1115 Research and Demonstration Waiver, "Medicaid Reform", on October 19, 2005. Florida initially implemented the program in Broward and Duval counties on July 1, 2006 and expanded to Baker, Clay, and Nassau counties on July 1, 2007.

On June 30, 2010, the Agency for Health Care Administration (Agency) submitted a three-year waiver extension request to maintain and continue operations of the Medicaid Reform program. Federal CMS approved the three-year waiver extension request on December 15, 2011 for the period December 16, 2011 through July 31, 2014.

On August 1, 2011, Florida submitted an amendment request to Federal CMS to change the name of the demonstration and implement the Managed Medical Assistance (MMA) program as specified in Part IV of Chapter 409, Florida Statutes (F.S.). The amendment allowed the state to implement a new statewide managed care delivery system without increasing costs and to continue the Low-Income Pool (LIP) program. On June 14, 2013, Federal CMS approved the amendment, along with amended Special Terms and Conditions (STCs), waiver and expenditure authorities. MMA program implementation began May 1, 2014 and was fully implemented in all regions by August 2014. On July 31, 2014, CMS approved the State's request for a three-year extension to the MMA 1115 waiver demonstration, along with newly amended STCs and waiver and expenditure authorities, through June 30, 2017.

The Agency contracted with the University of Florida (UF) to conduct an independent evaluation of the MMA program. UF subcontracted with two other universities to conduct some components of the evaluation (Florida State University and University of Alabama at Birmingham). The Agency provided the evaluators with a description of the objectives of the MMA program and the approved evaluation design.

UF submitted a Final Comprehensive Evaluation Report for DY9 (SFY 2014-15) to the Agency in September 2017. Targeted evaluation questions about the MMA program covered 18 unique domains of focus and were organized into the following five projects:

1. The effect of customized benefit plans and having separate plans for LTC and acute care services on beneficiaries' choice of plans, access to care, quality of care, and cost of care;
2. Healthy Behaviors Programs offered by the MMA plans;
3. MMA program's ability to deter fraud and abuse;
4. The effect of LIP on uncompensated care provided through hospital charity care programs; effect on access, quality and timeliness of care and emergency department usage for the uninsured; and, impact on costs for treating uninsured patients; and,
5. Outcomes for dual-eligible individuals enrolled in a Medicare Advantage Plan and a MMA plan.

The evaluation of the MMA program for DY9 (SFY 2014-15) yielded the following high-level findings:

- In the MMA period, there were sizable declines in service utilization compared to the pre-MMA period for the following:
    - Inpatient stays
    - Outpatient visits
    - Emergency Department visits
    - Professional (physician) visits
- Out of a subset of 26 HEDIS measures, approximately 65 percent (17 measures) of the statewide weighted means improved and 27 percent (7 measures) stayed the same after implementation of MMA. Only 8% (2 measures) declined after implementation.
- Per member per month (PMPM) costs adjusted for age, race, gender, and Chronic Illness and Disability Payment System (CDPS) scores (case-mix) for MMA services are 32.9 percent lower for comprehensive plans (serving both LTC and MMA enrollees) compared to PMPM costs for enrollees who are in separate LTC and MMA plans ($206 PMPM comprehensive vs. $306 PMPM separate).
- While the Florida transition to statewide managed care in 2014 was not without challenges, the overall success in implementing such a broad transformation in the span of a few short months, while reducing per member per month (PMPM) costs and maintaining or improving quality measures, stands as a considerable accomplishment.

  More details about DY9 findings, as well as for additional demonstration years, will be included in the Interim Draft Evaluation Report (available January 2022).

3. MMA Program Description and Objectives

Federal CMS approved a second extension of the MMA 1115 waiver demonstration (Project No. 11-W-00206/4) for a period of five years beginning August 3, 2017 through June 30, 2022. For the extension, CMS funded the LIP at approximately $1.5 billion annually based on the most recent available data on hospitals' charity care costs to ensure continuing support for safety-net providers that furnish uncompensated care to the Medicaid, uninsured, and underinsured populations. The STCs for the demonstration were modified to simplify and streamline reporting requirements and to remove requirements that are no longer applicable. All future references to the STCs in this document relate to the December 20, 2017 amended STCs unless otherwise indicated. Florida's 1115 demonstration allows the state to operate a capitated Medicaid managed care program. Under the demonstration, most Medicaid eligibles are required to enroll in one of the managed care plans contracted with the State. Several populations may also voluntarily enroll in managed care through the MMA program. The managed care plans in the MMA program are divided into "standard" and "specialty" plans. Specialty plans serve populations with distinct characteristics, diagnoses or chronic conditions. These plans are tailored to meet the specific needs of the specialty population.

Applicants for Medicaid are given the opportunity to select a managed care plan prior to receiving a Florida Medicaid eligibility determination. If they do not choose a plan, they are auto- assigned into a managed care plan upon an affirmative eligibility determination and subsequently provided with information about their choice of plans. Once an enrollee has selected or been assigned an MMA plan, the enrollee shall be enrolled for a total of 12 months,

until the next open enrollment period. The 12-month period includes a 120-day period to change or voluntarily disenroll from a plan without cause and select another plan.

Managed care plans may provide customized benefits to their members that differ from, but cannot be more restrictive than, the state plan benefits. Participating Medicaid eligibles also have access to Healthy Behaviors programs that provide incentives for adopting healthy behaviors.

4.1 Populations Covered in the MMA Program

MMA program enrollees include individuals eligible under the approved state plan or as a demonstration-only group, and who are described below as "mandatory enrollees" or as "voluntary enrollees." Mandatory enrollees are required to enroll in a MMA plan as a condition of receipt of Medicaid benefits. Voluntary enrollees are exempt from mandatory enrollment, but have the option to enroll in a demonstration MMA plan to receive Medicaid benefits.

1. **Mandatory Managed Care Enrollees** – Individuals who belong to the categories of Medicaid eligibles listed in Table 7 (and who are not listed as excluded from mandatory participation) are required to be MMA program enrollees.

Table 7. Mandatory and Optional State Plan Eligibility Group

Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Infants under age 1	No more than 206% of the Federal Poverty Level (FPL).	Title XIX	TANF & Related Group
Children 1-5	No more than 140% of the FPL.	Title XIX	TANF & Related Group
Children 6-18	No more than 133% of the FPL.	Title XIX	TANF & Related Group
Blind/Disabled Children	Children eligible under Supplemental Security Income (SSI), or deemed to be receiving SSI.	Title XIX	Aged/Disabled

Mandatory State Plan Eligibility Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
IV-E Foster Care and Adoption Subsidy	Children for whom IV-E foster care maintenance payments or adoption subsidy payments are received – no Medicaid income limit.	Title XIX	TANF & Related Group
Pregnant women	Income not exceeding 191% of FPL.	Title XIX	TANF & Related Group
Section 1931 parents or other caretaker relatives	No more than Aid to Families with Dependent Children (AFDC) Income Level (Families whose income is no more than about 31% of the FPL or $486 per month for a family of 3.)	Title XIX	TANF & Related Group
Aged/Disabled Adults	Persons receiving SSI, or deemed to be receiving SSI, whose eligibility is determined by the Social Security Administration (SSA).	Title XIX	Aged/Disabled
Former foster care children up to age 26	Individuals who are under age 26 and who were in foster care and receiving Medicaid when they aged out.	Title XIX	TANF & Related Group

Optional State Plan Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
State-funded Foster Care or Adoption assistance under age 18	Who receive a state Foster Care or adoption subsidy, not under title IV-E.	Title XIX	TANF & Related Group

Optional State Plan Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Individuals eligible under a hospice-related eligibility group	Up to 300% of SSI limit. Income of up to $2,130 for an individual and $4,260 for an eligible couple.	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special income level group specified at 42 CFR 435.236	This group includes institutionalized individuals eligible under this special income level group who do not qualify for an exclusion, or are not included in a voluntary participant category in STC 20(c).	Title XIX	Aged/Disabled
Institutionalized individuals eligible under the special home and community based waiver group specified at 42 CFR 435.217	This group includes institutionalized individuals eligible under this special HCBS waiver group who do not qualify for an exclusion, or are not included in a voluntary participant category in STC 20(c).	Title XIX	Aged/Disabled

Demonstration Only Groups	Population Description	Funding Stream	CMS-64 Eligibility Group Reporting
Aged or Disabled Individuals	*Income at or below 88% FPL *Assets that do not exceed $5,000 (individual) or $6,000 (couple) *Medicaid-only eligibles not receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Aged or Disabled Individuals	*Income at or below 88% FPL *Assets that do not exceed $5,000 (individual) or $6,000 (couple) *Medicaid-only eligibles receiving hospice, HCBS, or institutional care services	Title XIX	MEDS AD
Aged or Disabled Individuals	*Income at or below 88% FPL *Assets that do not exceed $5,000 (individual) or $6,000 (couple)	Title XIX	MEDS AD

	*Medicare eligible receiving hospice, HCBS, or institutional care services		
Individuals diagnosed with AIDS	*Have an income at or below 222% of the federal poverty level (or 300% of the benefit rate) *Have assets that do not exceed $2,000 (individual) or $3,000 (couple) and *Meet hospital level of care, as determined by the State of Florida	Title XIX	AIDS CNOM

Medicare-Medicaid Eligible Participants – Individuals fully eligible for both Medicare and Medicaid are required to enroll in an MMA plan for covered Medicaid services. These individuals will continue to have their choice of Medicare providers as this program will not impact individuals' Medicare benefits. Medicare-Medicaid beneficiaries will be afforded the opportunity to choose an MMA plan. However, to facilitate enrollment, if the individual does not elect an MMA plan, then the individual will be assigned to an MMA plan by the state using the criteria outlined in STC 25.

2. **Voluntary Enrollees** – The following individuals are excluded from mandatory enrollment into the MMA program under subparagraph (a) but may choose to voluntarily enroll under the demonstration, in which case the individual would be a voluntary participant in an MMA plan and would receive its benefits:

a) Individuals who have other creditable health care coverage, excluding Medicare;

b) Individuals age 65 and over residing in a mental health treatment facility meeting the Medicare conditions of participation for a hospital or nursing facility;

c) Individuals in an intermediate care facility for individuals with intellectual disabilities (ICF- IID);

d) Individuals with developmental disabilities enrolled in the home and community- based waiver pursuant to state law, and Medicaid recipients waiting for waiver services;

e) Children receiving services in a Prescribed Pediatric Extended Care (PPEC) facility; and

f) Medicaid-eligible recipients residing in group home facilities licensed under section(s) 393.067 F.S.

3. **Excluded from MMA Program Participation** - The following groups of Medicaid eligibles are excluded from enrollment in managed care plans:

a) Individuals eligible for emergency services only due to immigration status;

b) Family planning waiver eligible;

c) Individuals eligible as women with breast or cervical cancer; and,

d) Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law. (These individuals are inmates not eligible for covered services under the state plan, except as inpatients in a medical institution).

B. Evaluation Questions and Hypotheses

This section presents each evaluation component and its associated research questions. Note that for research questions focusing on cost and utilization, the pre-MMA period will include recipients enrolled in fee-for-service (FFS) Medicaid in addition to recipients enrolled in Reform and 1915b waiver plans. A driver diagram based on the components and their research questions is included at the end of this section (Figure 1).

The state of Florida established the MMA program with the goal to improve the quality, access, and costs of care for Florida's Medicaid enrollees. The Agency's specific goal for the managed care plans has been for the plans to reach the National Medicaid 75th percentile on HEDIS measures. The managed care plans' HEDIS rates each year are compared to the previous year National Medicaid percentiles to measure the plans' (and MMA program's) progress toward reaching the 75th percentile. The state's overall goal to improve the quality, access, and costs of care dictates that examining the changes in quality, access, and costs are key to gauging the success of the MMA program. The state therefore seeks a combination of (1) statistically significant beneficial changes in key measures (e.g., cost reductions, access improvements, quality increases) while (2) maintaining performance in those areas where statistically significant beneficial changes are not detected (i.e., not incurring statistically significant cost increases, access reductions, and quality decreases). Given the multitude of measures of cost, access, and quality and the varied populations served by Medicaid, it would be unrealistic to expect across-the-board improvements in every measure of performance for every population.

In keeping with the goals of the MMA demonstration, the State expects the demonstration to have an overall positive impact on Florida's efforts to improve its Medicaid program under a capitated managed care program.

Component 1. The effect of managed care on access to care, quality and efficiency of care, and the cost of care

Research Questions:

1A. *What barriers do enrollees encounter when accessing primary care and preventive services?*

Question 1A will be answered descriptively using AHCA complaint, grievance, and appeal

data and the Client Information & Registration Tracking (CIRTS) database from the MMA period, and to the extent possible, Medicaid Fair Hearing data. Hence, no hypotheses will be tested.

1B. *What changes in the accessibility of services occur with MMA implementation, comparing accessibility in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to MMA plans?*

Hypothesis 1B. *There will be no changes in the accessibility of services in MMA plans compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans).*

1C. *What changes in the utilization of services for enrollees are evident post-MMA implementation, comparing: 1) utilization of services in the pre-MMA period (FFS, Reform plans and pre-MMA 1915(b) waiver plans) to utilization of services in post-MMA implementation; 2) utilization of services in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in the specialty plans?*

Hypothesis 1C. *1) There will be no change in the use of services for enrollees in the MMA period compared to the pre-MMA period. 2) There will be no difference in use of services by enrollees in specialty MMA plans compared to use of services by enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are in standard MMA plans.*

1D. *What changes in quality of care for enrollees are evident post-MMA implementation, comparing: 1) quality of care in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to quality of care in MMA plans in the MMA period; 2) quality of care in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard plans versus enrollees in the specialty plans (to the extent possible)?*

Hypothesis 1D. *(1) There will be no change in the quality of care for enrollees in MMA plans compared to quality of care for enrollees in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans); and 2) There will be no difference in the quality of care for enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) in standard plans versus enrollees in specialty plans.*

1E. *What strategies are standard MMA and specialty MMA plans using to improve quality of care? Which of these strategies are most effective in improving quality and why?*

This question will be addressed using qualitative methods (no hypothesis).

1F. *What changes in timeliness of services occur with MMA implementation, comparing timeliness of services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to post-MMA implementation plans?*

Hypothesis 1F. *There will be no change in the* timeliness of services in MMA plans

compared to pre-MMA implementation plans (Reform plans and 1915(b) waiver plans).

1G. *What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (FFS, Reform plans and pre-MMA 1915(b) waiver plans) compared to per-enrollee costs in the MMA period (MMA plans as a whole, standard MMA plans and specialty MMA plans)?*

Hypothesis 1G. *There will be no difference in* the per-enrollee cost by eligibility group in MMA plans compared to pre-MMA implementation (FFS, Reform, and 1915 (b) waiver plans).

Component 2. The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care

Since the MMA plans do not offer customized benefit plans, the State will evaluate the effect of expanded benefits on enrollees' utilization of services, access to care, and quality of care.

Research Questions:

2A. *What is the difference in the types of expanded benefits offered by standard MMA and specialty MMA plans? How do plans tailor the types of expanded benefits to particular populations?*

2B. *How many enrollees utilize expanded benefits and which ones are most commonly used?*

Research questions 2A and 2B were included to provide context (description of plans with expanded benefits) for the analyses for this Component. Therefore, there are no hypotheses to test for these research questions.

2C. *How does Emergency Department (ED) and inpatient hospital utilization differ for those enrollees who use expanded benefits (e.g. additional vaccines, physician home visits, extra outpatient services, extra primary care and prenatal/perinatal visits, and over-the-counter drugs/supplies) vs. those enrollees who do not?*

Hypothesis 2C. *There will be no differences in ED and inpatient hospital utilization for users versus non-users of expanded benefits.*

The following question will be addressed beginning with the evaluation of DY14 (SFY 2019-20):

2D. *How do enrollees rate their experiences and satisfaction with the expanded benefits that are offered by their health plan?*

This research question will employ qualitative methods (no hypotheses).

Component 3. Participation in the Healthy Behaviors programs and its effect on participant behavior or health status

Research Questions:

Research Questions 3A-3D are included to provide context (description and number of Healthy Behaviors programs provided by plan as well as associated incentives and rewards) to analyses for this Component. Therefore, there are no hypotheses to be tested for these research questions.

3A. *What Healthy Behaviors programs do MMA plans offer? What types of programs and how many are offered in addition to the three required programs (medically approved smoking cessation program, the medically directed weight loss program, and the medically approved alcohol or substance abuse treatment program)?*

3B. *What incentives and rewards do MMA plans offer to their enrollees for participating in Healthy Behaviors programs?*

3C. *How many enrollees participate in each Healthy Behaviors program? How many enrollees complete Healthy Behaviors programs? Which types of Healthy Behaviors programs attract higher numbers of participants?*

3D. *How does participation in Healthy Behaviors programs vary by gender, age, race/ethnicity and health status of enrollees (DY13 and beyond)?*[33]

3E. *What differences in service utilization occur over the course of the demonstration for enrollees participating in Healthy Behaviors programs versus enrollees not participating (DY13 and beyond)?*

> ***Hypothesis 3Ei.*** *There will be no difference in utilization of 1) preventive services and 2) outpatient services between enrollees participating in Healthy Behaviors programs and enrollees not participating in Healthy Behaviors programs.*
>
> ***Hypothesis 3Eii.*** *There will be no change in the utilization of ER, inpatient and outpatient hospital and physician specialty services for treatment of conditions that these programs are designed to prevent or manage for enrollees after enrolling in the Healthy Behaviors program.*

[33] Questions 3D and 3E will be answered when individual-level Healthy Behaviors data for DY13 (SFY 2018-19) and subsequent years become available.

Component 4. The impact of LIP funding on hospital charity care programs

For DY10, the State will evaluate the impact of LIP funding on access to care for Medicaid uninsured and underinsured recipients. Beginning with DY11, the state will evaluate the impact of LIP funding on access to care for uncompensated charity care recipients.

Research Questions:

The following questions will be addressed in the evaluation of DY10 (SFY 2015-16):

4A. *What is the impact of LIP funding on access to care for Medicaid, uninsured, and underinsured recipients served in hospitals? That is, how many Medicaid, uninsured, and underinsured recipients receive services in LIP funded hospitals?*

> ***Hypothesis 4A.*** *There will be no impact of LIP funding on access to care for Medicaid, uninsured, and underinsured recipients served in hospitals.*

4B. *What types of services are being provided to Medicaid, uninsured, and underinsured recipients receiving care in LIP funded hospitals?*

> This research question is included to provide context (description of types of services being provided thorough LIP) for this component. Therefore, there is no hypothesis to test for this research question.

The following questions will be addressed beginning with the evaluation of DY11 (SFY 2016-17):

4C. *What is the impact of LIP funding on access to care for uncompensated charity care recipients served in hospitals? That is, how many uncompensated charity care recipients receive services in LIP funded hospitals? How does this compare among hospitals in different tiers of LIP finding?*

> ***Hypothesis 4C.*** *There will be no difference in 1) the number of uncompensated charity care patients served or 2) their expenditures based on 1) hospital access to LIP funding and 2) different tiers of LIP funding.*

4D. *What types of services are being provided to uncompensated charity care recipients receiving care in LIP funded hospitals?*

> This research question is included to provide context (description of types of services being provided through LIP) for this component. Therefore, there is no hypothesis to test for this research question.

4E. *What is the difference in the type and number of services offered to uncompensated charity care patients in hospitals receiving LIP funding?*

> ***Hypothesis 4E.*** *There will be no change in the types of services or the number of services offered to uncompensated charity care patients in hospitals receiving LIP funding.*

The following question will be addressed beginning with the evaluation of DY12 (SFY 2017-18):

4F. *What is the impact of LIP funding on the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician practices?*

> ***Hypothesis 4F.*** *LIP funding will have no effect on the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician practices.*

Component 5. The effect of having separate managed care programs for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care[34]

This component will sunset after the evaluation of DY12 (SFY 2017-18) because there will no longer be separate programs for acute (medical) care and LTC services beginning with the evaluation of DY13 (SFY 2018-19). All LTC enrollees will be in a plan that offers both acute (medical) care and LTC services.

Research Questions:

5A. *How many enrollees are enrolled in separate Medicaid managed care programs for acute (medical) care and LTC services?*

5B. *How many enrollees are enrolled in comprehensive plans for both acute (medical) care and LTC services?*

Research Questions 5A and 5B were included to provide context (descriptive information about enrollment of this population across plan types) for this Component. Therefore, there are no hypotheses associated with these research questions.

5C. *Are there differences in service utilization, as well as in the appropriateness of service utilization (to the extent this can be measured), between enrollees who are in a comprehensive plan for both MMA and LTC services versus those who are enrolled in separate MMA and LTC plans?*

> ***Hypothesis 5C.*** *There will be no difference in service utilization or in the appropriateness of service utilization between enrollees in comprehensive plans and enrollees in separate plans.*

Component 6. The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals

The State has elected to evaluate this component by focusing on the experiences of dual eligibles in receiving behavioral health services and non-emergency transportation services because these services are covered by Medicaid.

Research Questions:

6A. *How many MMA enrollees are also Medicare recipients (dual-eligibles) and to what extent do dual-eligible enrollees utilize behavioral health and non-emergency transportation services?*

[34] Component 5 will sunset following the evaluation of DY12 (SFY 2017-18).

Research Question 6A is included to provide context (descriptive information) for this Component, so there is no hypothesis to be tested for this question.

6B. *What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services and non-emergency transportation services for dual-eligible enrollees?*

6C. *How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to behavioral health and non-emergency transportation services?*

Research Questions 6B and 6C will be answered using qualitative methods; they are exploratory and descriptive in nature so there are no hypotheses to be tested.

Component 7. The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner

Research Questions:

These research questions will produce descriptive results comparing the time to service for enrollees (1) in general, (2) under auto-enrollment, and (3) who switch plans within 120 days. There are no hypotheses associated with these questions.

7A. *How quickly do new enrollees access services, including expanded benefits in excess of State Plan covered benefits, after becoming Medicaid eligible and enrolling in a health plan?*

7B. *Among new enrollees, what is the time to access services for enrollees who are enrolled under Express Enrollment compared to enrollees who were enrolled prior to the implementation of Express Enrollment?*

Component 8. The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services.

The research questions for this component will be addressed beginning with the evaluation of Demonstration Year 14 (SFY 2019-20).

Research Questions:

8A. *How does enrollee utilization of dental health services vary by age, gender, race/ethnicity, and geographic area?*

Research Question 8A is included to provide context (descriptive information) for this component, so there is no hypothesis to be tested for this question.

8B. *What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?*

Hypothesis 8B. *There will be no change in dental health service utilization with the implementation of the Statewide Medicaid Prepaid Dental Health Program.*

8C. *What changes in quality of dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?*

> ***Hypothesis 8C.*** *There will be no change in quality of dental health services with the implementation of the Statewide Medicaid Prepaid Dental Health Program.*

8D. *What changes in the accessibility of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?*

> ***Hypothesis 8D.*** *There will be no change in accessibility of dental services with the implementation of the Statewide Medicaid Prepaid Dental Health Program.*

8E. *What barriers do enrollees encounter when accessing dental health services?*

8F. *How many enrollees utilize expanded benefits provided by the dental health plans and which ones are most commonly used?*

> Research Questions 8E and 8F will be answered descriptively. Hence, no hypotheses will be tested.

8G. *How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)? How does utilization of expanded benefits offered by the dental health plans impact dental-related hospital events?*

> ***Hypothesis 8G.*** *There will be no impact on dental-related hospital events (e.g., Emergency Department, Inpatient Hospitalization) resulting from enrollee utilization of dental health services or utilization of expanded benefits offered by dental health plans.*

8H*. What changes in per-enrollee cost for dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?*

> ***Hypothesis 8H.*** *There will be no change in per-enrollee cost for dental health services with the implementation of the Statewide Medicaid Prepaid Dental Health Program.*

8I. *How do enrollees rate their experiences and satisfaction with dental health services, including timeliness of dental health services, provided by their dental health plans?*

8J. *How do enrollees rate their experiences and satisfaction with the expanded benefits offered by their dental health plans?*

Research Questions 8I and 8J will be answered using qualitative methods; they are exploratory and descriptive in nature so there are no hypotheses to be tested.

Component 9. The impact of the waiver of retroactive eligibility on beneficiaries and providers.

The research questions for this component will be addressed beginning in January of 2020 when the initial encounter data reflective of the waiver of retroactive eligibility become available.

Research Questions:

9A. *How will eliminating or reducing retroactive eligibility change enrollment continuity?*

Hypothesis 9A. *Eliminating or reducing retroactive eligibility will have no effect on enrollment continuity.*

9B. *How will eliminating or reducing retroactive eligibility change the enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility?*

Hypothesis 9B. *Eliminating or reducing retroactive eligibility will have no effect on the health status of those subject to the new policy compared to those not subject to the new policy.*

9C. *How will eliminating or reducing retroactive eligibility affect new enrollee financial burden?*

Hypothesis 9C. *Eliminating or reducing retroactive eligibility will have no effect on new enrollee financial burden.*

Note: Results from 9C will determine whether 9D through 9F are applicable.

9D. *How will eliminating or reducing retroactive eligibility affect provider uncompensated care amounts?*

Hypothesis 9D. *Eliminating or reducing retroactive eligibility will have no effect on provider uncompensated care amounts.*

9E. *How will eliminating or reducing retroactive eligibility affect provider financial performance (income after expenses)?*

Hypothesis 9E. *Eliminating or reducing retroactive eligibility will have no effect on provider financial performance (income after expenses).*

9F. *How will eliminating or reducing retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?*

Hypothesis 9F. *Eliminating or reducing retroactive eligibility will have no effect on the net financial impact of uncompensated care (UCC – LIP payments).*

Component 10. The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability.

Note: Research Question 10F will be answered dependent on data availability.

Research Questions

10A. How many MMA plans participate in the Housing Assistance Services pilot program? How many enrollees are participating in the housing assistance services program, by plan? How does participation in the housing assistance services program vary by gender, age, race/ethnicity and health status of enrollees?

Hypothesis 10A. These questions are included to provide context and descriptive information about how the pilot is being implemented by the MMA plans; therefore, there is no hypothesis to test.

10B. What is the frequency and duration of use for the specific services (transitional housing services, mobile crisis services, peer support, tenancy services) offered by the housing assistance program by plan? What is the proportion of enrollees who are successfully discharged from the pilot but subsequently become homeless again and resume using services?

Hypothesis 10B. This question is included to provide context and descriptive information about how the pilot is being implemented by the MMA plans; therefore, there is no hypothesis to test.

10C. Based on Medicaid data submitted by the MMA plans, do enrollees in the study population have fewer avoidable hospitalizations and emergency department visits than they did prior to receiving housing assistance services?

Hypothesis 10C. There will be fewer avoidable hospitalizations and emergency department visits among enrollees with SMI who receive supportive housing assistance compared to enrollees who did not receive supportive housing assistance.

10D. Are there changes in utilization of MMA services (specifically PCP visits, Outpatient visits, pharmacy services and behavioral health services) in the study population compared to their service utilization prior to participation in the Pilot program?

Hypothesis 10D. Use of MMA services will be greater among enrollees with SMI who receive supportive housing assistance compared to enrollees who did not receive supportive housing assistance.

10E. Based on interviews with MMA plan staff, including Care Coordinators, is care coordination more effective for the study population as a result of the Pilot program?

Hypothesis 10E. This research question will be answered using qualitative methods; it is exploratory and descriptive in nature so there is no hypothesis to be tested.

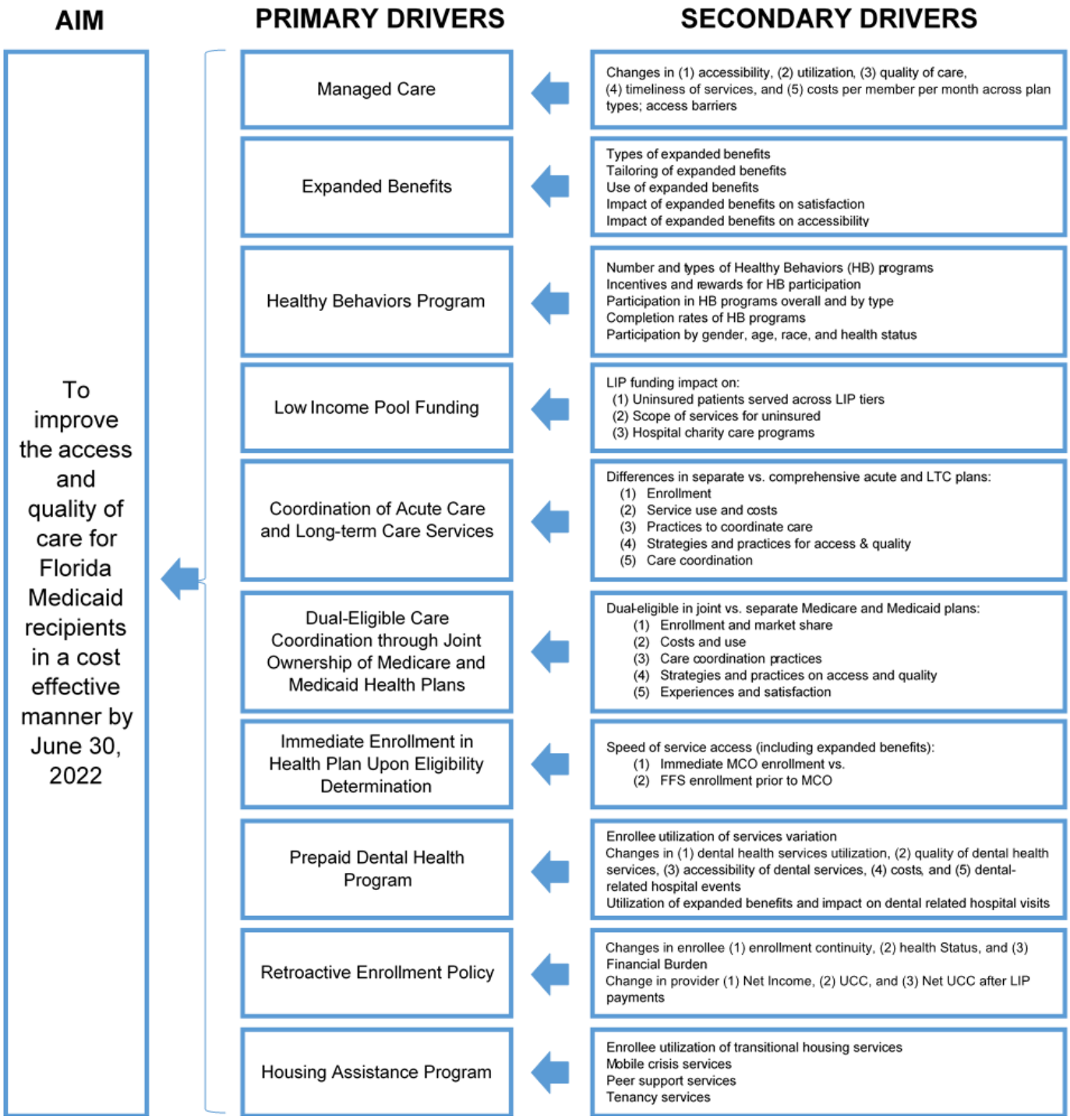
10F. What are the effects of housing on reductions in police interactions, arrests, and incarcerations?

Hypothesis 10F. Enrollees with SMI who receive Housing Assistance Services will have fewer police interactions, arrests, and incarcerations compared to similar enrollees who do not use Housing Assistance Services.

Driver Diagram

The Driver Diagram below presents the overarching goal of the demonstration and provides readers with a visual aid for understanding the rationale behind the cause and effect of the variants behind the demonstration's aim to improve health outcomes for Florida Medicaid recipients while maintaining fiscal responsibility. As depicted in the diagram, the overall goal is to utilize all financial and stakeholder resources to improve the access and quality of care in a cost effective manner for Florida Medicaid recipients.

Figure 5. Florida Managed Medical Assistance Program Goals: Driver Diagram



C. Methodology

This evaluation will employ a variety of quantitative and qualitative methods to answer its research questions and test its hypotheses. Quantitative methods will involve pre-post and post-only comparisons depending on whether the research question is focused on (1) comparing Medicaid performance following MMA implementation to Medicaid performance in the pre-MMA period or (2) the operations of the MMA program following implementation, respectively. Qualitative methods will involve (1) surveys and semi-structured interviews of

MMA plan personnel and dual-eligible Medicaid enrollees and (2) content analyses of MMA plan policies and procedures. The remainder of this section provides more detail on the (1) evaluation design, (2) target and comparison populations, (3) evaluation period, (4) evaluation measures, (5) data sources, and (6) analytic methods.

A useful summary of the methodologies employed in this evaluation can be found in Table 12 "Design Table for the Evaluation of the Demonstration," at the end of this methodology section. Table 12 lists each research question within each component along with the outcome measures, sample or population subgroups to be compared, data sources, and analytic methods used for that research question.

Numerous research questions in this MMA evaluation have associated null statistical hypotheses. Null hypotheses are typically expressed as involving no change in the variable under study, e.g., "There will be no change in costs when moving from FFS to managed care." Such null hypotheses are tested against either one-tailed or two-tailed alternative hypotheses. One-tailed alternative hypotheses (e.g., "Costs will go up in moving from FFS to managed care" or "Costs will go down in moving from FFS to managed care") are appropriate when there is an expected direction of change in the variable under study, such as when quantitative program targets have been established (e.g., "Health care costs will decrease by 5%"). By contrast, two- tailed alternative hypotheses (i.e., "The change in cost in moving from FFS to managed care will not equal zero.") are appropriate to test for changes that could be either positive or negative.

This evaluation employs two-tailed alternative hypotheses because the direction of change induced by the MMA program is not always clear a priori. Also, evaluation results for DY9 demonstrated that some specific measures (e.g., some categories of costs) may increase while other specific measures may decrease. When changes occur in the opposite direction to what is expected using one-tailed alternative hypotheses, statistical testing can only result in a failure to reject the null hypothesis of zero change. Statistically speaking, this is an inconclusive result. By contrast, two-tailed alternative hypotheses allow rejection of the null hypothesis of zero change in favor of the alternative hypothesis of non-zero change.

1. Evaluation Design

This evaluation employs both pre-post and post-only analyses as appropriate for the research question under examination. For example, for Research Question 1G, "What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (Fee For Service (FFS), Reform plans and pre-MMA 1915(b) waiver plans) compared to per enrollee costs post-MMA implementation (MMA plans as a whole, standard MMA plans and specialty MMA plans)?", a pre-post perspective is required.

The qualitative design is discussed in the context of specific research questions in "Analytic Methods" below.

2. Target and Comparison Populations

The target and comparison populations vary across the research questions and are driven by (1) the pre-post or post-only focus of the research question, and (2) the specific population focus of the research question, e.g., enrollees in standard MMA plans vs. enrollees in specialty MMA plans. The population foci of individual research questions are listed in Table 12 below.

3. Evaluation Period

The evaluation period began with SFY 2014-15 (Demonstration Year 9 (DY9)) and extends through SFY 2021-22 (DY16). SFY 2011-12 (DY6) and SFY 2012-13 (DY7) comprise the pre-MMA period and are used as a baseline for this evaluation, while SFY 2014-15 (DY9) through SFY 2021-22 (DY16) comprise the MMA period. SFY 2013-14 (DY8) was the implementation year for the MMA program and was excluded from this evaluation in order to avoid any data issues created by the transition from claims reporting to encounter reporting.

As of November 2017, the first MMA evaluation report compared quality, access, and cost measures during the pre-MMA period (SFY 2011-12 and SFY 2012-13) to the first complete year of the MMA period (SFY 2014-15). Subsequent evaluation reports will incorporate additional years from the MMA period as data become available and will focus on the evolution of the MMA program impacts across time.

4. Evaluation Measures

This evaluation uses a wide variety of measures of quality, access, and costs. Table 67 and Table 68, below, list the CAHPS and HEDIS measures, and Table 69 lists additional measures used in this evaluation.

Table 67. CAHPS Measures Used in the Evaluation

Measure	CAHPS Version 5 Adult & Child Questions for MMA Evaluation
Getting Needed Care (Adult and Child)	Percentage of respondents reporting it is usually or always easy to get needed care (vs. sometimes or never)
Getting Care Quickly (Adult and Child)	Percentage of respondents reporting it is usually or always easy to get care quickly (vs. sometimes or never)
Rate the Number of Doctors(Adult and Child)	Percentage of respondents rating the number of doctors to choose from as excellent or very good (vs. good, fair, or poor)
Health Plan Information and Customer Service (Adult and Child)	Percentage of respondents reporting they usually or always get the help/information needed from their plan's customer service staff (vs. sometimes or never)
Overall Rating of Health Plan (Adult and Child)	Percentage of respondents rating their plan an 8, 9 or 10 on a scale of 0 (worst) – 10 (best)
Overall Rating of Health Care (Adult and Child)	Percentage of respondents rating their health care an 8, 9 or 10 on a scale of 0 (worst)- 10 (best)

Shared Decision-Making (Adult and Child)	Percentage of respondents reporting there is shared decision-making between the provider and respondent (Yes vs. No)
Overall Rating of Personal Doctor (Adult and Child)	Percentage of respondents rating their doctor an 8, 9, or 10 on a scale of 0 (worst)- 10 (best)
Overall Rating of Specialist	Percentage of respondents rating their specialist an 8, 9, or 10 on a scale of 0 (worst)- 10 (best)

Measure	Patient Experience Measures for the CAHPS Dental Plan Survey*
Care from Dentists and Staff	Percentage of respondents reporting their regular dentist usually or always explains things in a way that is easy to understand (vs. sometimes or never) Percentage of respondents reporting their regular dentist usually or always listens to them carefully (vs. sometimes or never) Percentage of respondents reporting their regular dentist usually or always treats them with courtesy and respect (vs. sometimes or never) Percentage of respondents reporting their regular dentist usually or always spends enough time with them (vs. sometimes or never) Percentage of respondents reporting dentists or dental staff usually or always do everything they can to help them feel as comfortable as possible during their dental work (vs. sometimes or never) Percentage of respondents reporting that their dentists or dental staff usually or always explain what they are doing while treating them (vs. sometimes or never)
Access to Dental Care	Percentage of respondents reporting their dental appointments are usually or always as soon as they want (vs. sometimes or never) Percentage of respondents reporting they usually or always get an appointment with their dental specialist as soon as they want (vs. sometimes or never) Percentage of respondents reporting they usually or always spend 15 minutes or less in the waiting room before seeing someone for their appointment (vs. sometimes or never) Percentage of respondents reporting someone usually or always tells them why there is a delay or how long the delay will be if they have to wait more than 15 minutes in the waiting room before being seen for an appointment (vs. sometimes or never) Percentage of respondents answering "somewhat yes" or "definitely yes" when asked whether they get to see a dentist as soon as they want if they have a dental emergency (vs. "somewhat no" or "definitely no")

Dental Plan Coverage and Services	Percentage of respondents reporting their dental plan usually or always covers all of the services they think are covered (vs. sometimes or never) Percentage of respondents reporting that the 800 number, written materials, or website usually or always provides the information they want (vs. sometimes or never) Percentage of respondents reporting their dental plan's customer service usually or always gives them the information they want or the help they need (vs. sometimes or never) Percentage of respondents reporting their dental plan's customer service staff usually or always treats them with courtesy and respect (vs. sometimes or never)

	Percentage of respondents answering "somewhat yes" or "definitely yes" when asked whether their dental plan covers what they and their family need to get done (vs. "somewhat no" or "definitely no") Percentage of respondents answering "somewhat yes" or "definitely yes" when asked whether information from their dental plan helps them find a dentist they are happy with (vs. "somewhat no" or "definitely no")
Patients' Rating	Percentage of respondents rating their regular dentist an 8, 9, or 10 on a scale of 0 (worst) to 10 (best) Percentage of respondents rating all dental care they personally received in the last 12 months an 8, 9, or 10 on a scale of 0 (worst) to 10 (best) Percentage of respondents rating how easy it was to find a dentist an 8, 9, or 10 on a scale of 0 (extremely difficult) to 10 (extremely easy) Percentage of respondents rating their dental plan an 8, 9, or 10 on a scale of 0 (worst dental plan possible) to 10 (best dental plan possible)

*Many of the dental survey items will be grouped into one overarching composite measure

Table 68. HEDIS and Other Performance Measures Used in the Evaluation

Measure	Components	Steward/Source	CMS Adult/Child Core Measure?	NQF #
Adolescent Well-Care Visits	--	NCQA HEDIS	Child	--
Adults' Access to Preventive/Ambulatory Health Services	20-44 years 45-64 years 65+ years Total	NCQA HEDIS	--	--
Breast Cancer Screening	--	NCQA HEDIS	Adult	2372
Cervical Cancer Screening	--	NCQA HEDIS	Adult	0032
Childhood Immunization Status	Combo 2 Combo 3	NCQA HEDIS	Child	0038
Children and Adolescents' Access to Primary Care Practitioners	12-24 months 25 mos –6 yrs 7-11 years 12-19 years	NCQA HEDIS	Child	--
Chlamydia Screening in Women	16-20 years 21-24 years Total	NCQA HEDIS	Child and Adult	0033

HIV-Related Outpatient Medical Visits	≥ 2 visits (182 days apart)	Agency-defined	--	--

Measure	Components	Steward/Source	CMS Adult/Child Core Measure?	NQF #
(Note – This measure will not be reported after CY 2016 data)				
Immunizations for Adolescents	Combination 1	NCQA HEDIS	Child	1407
Lead Screening in Children	--	NCQA HEDIS	--	--
Prenatal and Postpartum Care	Prenatal Postpartum	NCQA HEDIS	Child (Prenatal) and Adult (Postpartum)	1517
Frequency of Ongoing Prenatal Care/Prenatal Care Frequency	≥ 81% of expected visits	NCQA HEDIS/Agency-defined	Child	1391
Transportation Availability (Note – This measure will not be reported after CY 2016 data)		Agency-defined	--	--
Well-Child Visits in the First 15 Months of Life	0 visits 6+ visits	NCQA HEDIS	Child	1392
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	--	NCQA HEDIS	Child	1516
Adult BMI Assessment		NCQA HEDIS	Adult	--
Antidepressant Medication Management	Acute; Continuation	NCQA HEDIS	Adult	0105
Comprehensive Diabetes Care	HbA1C Testing	NCQA HEDIS	Adult	0057
Comprehensive Diabetes Care	HbA1c Good Control	NCQA HEDIS	--	0575
Comprehensive Diabetes Care	HbA1c Poor Control	NCQA HEDIS	Adult	0059
Comprehensive Diabetes Care	Eye Exam	NCQA HEDIS	--	0055

Measure	Components	Steward/Source	CMS Adult/Child Core Measure?	NQF #
Comprehensive Diabetes Care	Nephropathy	NCQA HEDIS	--	0062
Comprehensive Diabetes Care	LDL-C Screening	NCQA HEDIS	Adult	0063
Comprehensive Diabetes Care	LDL-C Control	NCQA HEDIS	Adult	0064
Controlling High Blood Pressure		NCQA HEDIS	Adult	0018
Follow-up After Hospitalization for Mental Illness	7-day 30-day	NCQA HEDIS	Adult	0576
Follow-up Care for Children Prescribed ADHD Medication	Continuation and Maintenance	NCQA HEDIS	Child	0108
Highly Active Anti-Retroviral Treatment		Agency-defined	--	
Mental Health Readmission Rate		Agency-defined	--	
Medication Management for People with Asthma		NCQA HEDIS	--	1799
Transportation Timeliness		Agency-defined	--	
Dental Performance Measures				
Annual Dental Visit	Total	NCQA HEDIS		1388
Preventive Dental Services		CMS Medicaid & CHIP Child Core Set	Child	—
Dental Treatment Services		Agency-defined/CMS-416 Data	Child	—
Sealants for 6-9 Year-old Children at Elevated Caries Risk		CMS Medicaid & CHIP Child Core Set/Dental Quality Alliance (DQA)	Child	2508

Measure	Components	Steward/Source	CMS Adult/Child Core Measure?	NQF #
Oral Evaluation		DQA/NQF	Child	2517
Topical Fluoride for Children at Elevated Caries Risk		DQA/NQF	Child	2528
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children		DQA/NQF	Child	2689
Follow-up after Emergency Department Visits for Dental Caries in Children		DQA/NQF	Child	2695

The following provides descriptions and numerators/denominators for the seven Agency-defined measures shown in Table 68, above:

HIV-Related Outpatient Medical Visits – (HIVV)

Description: The percentage of enrollees who were seen on an outpatient basis with HIV/AIDS as the primary diagnosis by a physician, Physician Assistant or Advanced Registered Nurse Practitioner for an HIV-related medical visit within the measurement year.

Eligible Population: Enrollees with HIV/AIDS as identified by at least one encounter with an ICD-9-CM diagnosis code 042, 079.53, 795.71, or V08 during the first six months of the measurement year.

Denominator: The eligible population.

Numerator: Four separate numerators are calculated:

a. Enrollees who were seen twice in measurement year, >= 182 days apart.
b. Enrollees who were seen twice or more in measurement year.
c. Enrollees who were seen exactly once in the measurement year.
d. Enrollees who were not seen during the measurement year.

***Note:** Numerators a and b are not mutually exclusive.

Prenatal Care Frequency (PCF)

Description: The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received greater than or equal to 81 percent of expected visits.

Administrative/Hybrid Specifications: Follow the specifications for the HEDIS measure, *Frequency of Ongoing Prenatal Care (FPC)*, most recent edition, with the following modification:

For those enrollees whose number of expected prenatal care visits is greater than 10, per Table FPC-A, the health plan should consider the enrollee having met the threshold for the greater than or equal to 81 percent of expected visits category if she received at least 10 visits. Report only the greater than or equal to 81 percent category.

Transportation Availability (TRA)

Description: The percentage of requests for transport that resulted in a transport.

Denominator: The number of requests for a transport to a Medicaid service made within the required time frames.

Numerator: The number of transports delivered.

Highly Active Anti-Retroviral Treatment – (HAART)

Description: The percentage of enrollees with a HIV/AIDS diagnosis that have been prescribed Highly Active Anti-Retroviral Treatment.

Eligible Population: Enrollees with HIV/AIDS as identified by at least one encounter with ICD-10-CM diagnosis code B20, B97.35, or Z21 during the first six months of the measurement year.

Denominator: Number of enrollees in the plan diagnosed with HIV/AIDS.

Numerator: Number of enrollees who were prescribed a HAART* regimen within the measurement year.

Mental Health Readmission Rate (RER)

Description: The percentage of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis that resulted in a readmission for a mental health diagnosis within 30 days.

Age: 6 years and older as of the date of discharge.

Denominator: Discharges to the community from an acute care facility (inpatient or crisis stabilization unit) with a principal diagnosis of mental illness and that met continuous enrollment criteria. Please refer to the Mental Illness Value Set in the most recent edition of the HEDIS Technical Specifications for Health Plans for the FUH measure and follow the steps found in the HEDIS Technical Specifications to identify acute inpatient discharges.

Numerator: Discharges that result in a readmission to an acute care facility (inpatient or crisis stabilization unit) with a principal diagnosis of mental illness and that met continuous enrollment criteria. Please refer to the Mental Illness Value Set in the most recent edition of the HEDIS Technical Specifications for Health Plans for the FUH measure and follow the steps found in the HEDIS Technical Specifications to identify acute inpatient discharges.

Transportation Timeliness (TRT)

Description: The percentage of transports where the enrollee was delivered to the service provider prior to the scheduled appointment time.

Denominator: The number of transports scheduled for an appointment for a Medicaid service.

Numerator: The number of transports where the enrollee was delivered to the service provider prior to or at the exact scheduled appointment time.

Dental Treatment Services

Description: The percentage of individuals ages 1 to 20 who are enrolled in the plan for at least 90 continuous days, are eligible for EPSDT services, and who received at least one dental treatment service during the reporting period.

Denominator: The total unduplicated number of individuals ages 1-20 that have been continuously enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 days and are eligible to receive EPSDT services.

Numerator: The unduplicated number of individuals receiving at least one dental treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000-D9999 (CDT codes D2000-D9999) or equivalent CPT codes, that is, only those CPT codes that involved periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services.

Table 69 lists the additional measures used in this evaluation beyond the HEDIS and CAHPS measures presented in Tables 2 and 3. These additional measures deal with

- Enrollee grievances and complaints,
- Service use,
- PCP appointment wait times,
- Mean costs by type of service,
- Expanded benefit types,
- Common themes from plan interviews,
- Types of Health Behaviors programs and incentives, and
- Enrollee participation and completion rates in Healthy Behaviors programs.

Measures of costs and utilization in Table 4 will vary depending on the research question and the type of care (e.g., inpatient or outpatient) under study. When enrollee encounter cost and utilization data are employed, the units of measurement for utilization will depend upon the definition of utilization reported in the encounter data. While cost data will be measured in dollars, the measurement of costs will differ depending on (1) whether the focus is on overall program efficiency where claim amounts and capitation payments will be used for the pre-MMA and MMA periods, respectively, or (2) the focus in on the cost of individual services where claims amounts and amounts paid by the MCO to the provider will be used for the pre-MMA and MMA periods, respectively.

Table 69. Additional Measures used in the Evaluation

Measure	Description	Research Question(s)
Plan Reported Enrollee Issues/Grievances	Number of grievances and appeals by type	1A
Access to care issues/complaints (by plan type)	Extract from Agency's Client Information & Registration Tracking database. Type of complaint (e.g. access, quality of care)	1A
Service Utilization. Use Claims and encounter data		
Inpatient	Per Member Per Month (PMPM) average number of visits that a Medicaid enrollee had in a month	1C
Outpatient	PMPM average number of visits that a Medicaid enrollee had in a month	1C
ED	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Professional Physician	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Specialist	PMPM average number of visits that a Medicaid enrollee had in a month	1C
Service Use per Enrollee per Year. Service utilization is per actual enrollee year. Statistical analysis of use to rely on binomial regression models of service use by the type of service		
Hospital Inpatient Admissions	Mean Service Use	5C
Hospital Inpatient Days	Mean Service Use	5C
Hospital Outpatient Visits	Mean Service Use	5C, 10D
Physician Primary Care Visits	Mean Service Use	5C, 10D
Physician Specialist Visits	Mean Service Use	5C
Pharmacy Claims	Mean Service Use	5C, 10D
Emergency Dept. Visits	Mean Service Use	5C
LTC Services	Mean Service Use	5C
Assisted Living	Mean Service Use	
HCBS	Mean Service Use	5C
Home Health	Mean Service Use	5C
Hospice	Mean Service Use	5C
Nursing Home	Mean Service Use	5C
Transitional Housing Services	Mean Service Use	10B
Mobile Crisis Services	Mean Service Use	10B
Peer Support Services	Mean Service Use	10B
Tenancy Services	Mean Service Use	10B
Potentially Preventable Hospitalizations	Mean Service Use	10C
Potentially Preventable Emergency Department Visits	Mean Service Use	10C
Behavioral Health Services	Mean Service Use	10D
Law Enforcement Contacts per Year. Use Department of Law Enforcement Data and Department of Corrections Data		
Police Interactions	Mean number of interactions	10F
Arrests	Mean number of arrests	10F
Incarcerations	Mean number of incarcerations	10F

Average PCP Appointment Wait Times. Average appointment wait times. Data Source: Timely Access PCP Wait Times Report		
Urgent Care	Days	1F
Routine Sick	Days	1F
Wellcare Visit	Days	1F
Mean Costs. Cost of specific MMA services will be obtained from the amount paid by the MMA plan to the provider in the encounter record. For MMA period comparisons to the pre-MMA periods, MMA capitation payments will be used as a measure of the cost to Medicaid under MMA.		
Total MMA and LTC Costs Combined	Per Member Per Month Mean Cost	1G

Measure	Description	Research Question(s)
Total MMA	Per Member Per Month Mean Cost	1G
Hospital Inpatient	Per Member Per Month Mean Cost	1G
Hospital Outpatient	Per Member Per Month Mean Cost	1G
Physician Primary Visit	Per Member Per Month Mean Cost	1G
Physician Specialist Visit	Per Member Per Month Mean Cost	1G
Pharmacy Cost	Per Member Per Month Mean Cost	1G
Emergency Dept. Cost	Per Member Per Month Mean Cost	1G
Total LTC Costs	Per Member Per Month Mean Cost	1G
Assisted Living Costs	Per Member Per Month Mean Cost	1G
HCBS Costs	Per Member Per Month Mean Cost	1G
Home Health Costs	Per Member Per Month Mean Cost	1G
Hospice Costs	Per Member Per Month Mean Cost	1G
Nursing Home Costs	Per Member Per Month Mean Cost	1G
Expanded Benefits Offered by Plans		
Adult Dental Services	Presence or Absence and Summary Counts	2A
Adult Influenza Vaccine	Presence or Absence and Summary Counts	2A
Adult Pneumonia Vaccine	Presence or Absence and Summary Counts	2A
Adult Shingles Vaccine	Presence or Absence and Summary Counts	2A
Art Therapy	Presence or Absence and Summary Counts	2A
Equine Therapy	Presence or Absence and Summary Counts	2A
Hearing Services	Presence or Absence and Summary Counts	2A
Home Health (non-pregnant adults)	Presence or Absence and Summary Counts	2A
Medically Related Lodging & Food	Presence or Absence and Summary Counts	2A
Newborn Circumcisions	Presence or Absence and Summary Counts	2A
Nutritional Counseling	Presence or Absence and Summary Counts	2A
Extra Outpatient Services	Presence or Absence and Summary Counts	2A
Over-The Counter Drugs/ Supplies Aid	Presence or Absence and Summary Counts	2A
Pet Therapy	Presence or Absence and Summary Counts	2A
Physician Home Visits	Presence or Absence and Summary Counts	2A
Post-Discharge Meals	Presence or Absence and Summary Counts	2A
Extra Prenatal/ Perinatal Visits	Presence or Absence and Summary Counts	2A
Extra Primary Care Visits	Presence or Absence and Summary Counts	2A
Vision Services	Presence or Absence and Summary Counts	2A

Waived Co-payments	Presence or Absence and Summary Counts	2A
Total Number of Expanded Benefits	Presence or Absence and Summary Counts	2A

Plan Interviews – Most Common Themes		
Quality of Care	% of content	1E
Behavioral Health	% of content	6B
Non-emergency Transportation	% of content	6B
Housing Services Care Coordination	% of content	10E
Types of Healthy Behaviors Programs and Incentives **Data Source: Quarterly Healthy Behaviors Summary Reports**		
Medically Approved Smoking Cessation Program	#, incentives and value	3A, 3B, 3C
Medically Directed Weight Loss Program	#, incentives and value	3A, 3B, 3C
Medically Approved Alcohol or Substance Abuse Recovery Program	#, incentives and value	3A, 3B, 3C
Preventive Well Child Care	#, incentives and value	3A, 3B, 3C
Prenatal, Maternity, & Postpartum Visits	#, incentives and value	3A, 3B, 3C
Preventive Adult Care (PCP visits)	#, incentives and value	3A, 3B, 3C
Mammograms	#, incentives and value	3A, 3B, 3C
Cervical Cancer Screening	#, incentives and value	3A, 3B, 3C
Enrollee Participation and Completion Rates in Healthy Behaviors Programs (Mandatory and Optional)		

Number currently enrolled	#	3C
Enrollees who completed program	#	3C
Plans Offering Program	#	3C
Plan with Most Participants	#	3C
By Gender	# (Male, Female)	3D
By Age Group	# (Age Grp 0-20, 21-40, 41-60, over 60)	3D

5. Data Sources

This evaluation will collect both quantitative and qualitative data from a variety of sources as outlined below in Table 5, "Quantitative and Qualitative Data Sources for Florida MMA Evaluation". Quantitative data will be collected predominantly from secondary sources (e.g., claims and encounter data, HEDIS performance reports, state MCO performance reports, etc.). The sole exception involving collecting primary quantitative data will involve collecting dual-eligible care coordination experiences via telephone surveys using closed-end questions.

Qualitative data will be collected using both semi-structured interviews and review of policies and procedures documents. Fully coded transcriptions of qualitative interviews will be analyzed through iterations of content analysis and grounded theory to identify salient themes.

The cleaning of Medicaid eligibility, enrollment, encounter, and claims data is done by both the Agency and the evaluation team. The eligibility, enrollment, encounter, and claims data used in his evaluation comes from the Agency's Special Feed database. These data are more extensively error-checked by the Agency upon receipt to ensure that the data are complete and error-free.

The evaluation team conducts additional checks related to data integrity upon receipt of the Special Feed data. "Filler" codes for character variables are checked (e.g., "####" or "****") and detected filler values are set to missing. Range-checking for both numeric and character variables as well as logical consistency checks are made among age, sex, diagnosis and procedure codes. Missingness rates are calculated for each variable in each dataset and compared to missingness rates in previous years of similar data. Voided claims (detail status =
V) are removed, as are preliminary records that have been superseded by subsequent revised entries.

These additional checks routinely produce questions from the evaluation team for the Agency data team concerning errors and anomalies. Answers given by the Agency data team are documented for future reference. Questions that cannot be readily answered are resolved by the involvement of additional data personnel and/or the transmittal of corrected data as needed. The HEDIS and CAHPS data used in this evaluation are independently audited prior to being submitted to the Agency. Similarly, Florida hospital discharge, emergency department, and

ambulatory surgery center data are cleaned and error-checked by the Florida Health Data Center upon receipt.

Table 70. Quantitative and Qualitative Data Sources for Florida MMA Evaluation

Data Source	Time Period*	Variables
Medicaid claims, eligibility, enrollment and encounter data	Pre-MMA MMA	Pre-MMA Inclusion criteria ▪ All eligibility categories that are mandated to enroll in a MMA health plan and received services through any delivery system for at least one month during the pre-MMA time period. Note that enrollees gradually transitioned to MMA health plans beginning May 1, 2014, thus some data during the implementation period will be coded as MMA during months where the enrollee was enrolled in a MMA health plan; ▪ All claims and encounter data for drugs and services that are required to be covered by MMA plans; and ▪ All voluntary MMA participants who received services through any delivery system. Exclusion criteria ▪ All groups explicitly excluded from MMA program participation. Demographic and health status characteristics MMA Inclusion criteria ▪ All eligibility categories that are mandated to enroll in a MMA plan and were enrolled in a MMA plan for at least one (1) month during May 1, 2014 – June 30, 2017. ▪ All voluntary MMA participants; and ▪ All claims and encounter data for drugs and services that are required to be covered by MMA plans. Exclusion criteria ▪ All groups explicitly excluded from MMA program participation. Demographic and health status characteristics
Consumer Assessment of Health Care Providers and Systems (CAHPS)	Pre-MMA MMA	See Table 2 above for a complete listing of the proposed CAHPS measures for this evaluation.
CAHPS Dental Plan Survey	MMA	See Table 2 above for a complete listing of the proposed dental CAHPS measures for this evaluation.

Data Source	Time Period*	Variables
HEDIS & Agency-defined performance measures, including CMS Child and Adult Core Measures	Pre-MMA (where available): Annual Means CYs 2011-2013 MMA: Annual Means CY 2015 through latest date when complete data is available	See Table 3 above for a complete listing of the proposed HEDIS and Agency-defined performance measures for this evaluation.
Dental Performance Measures	MMA	See Table 3 above for a complete listing of the proposed dental performance measures for this evaluation.
Managed Care Plans' Enrollee Complaint, Grievance, and Appeals Reports	MMA	Number of grievances and appeals by type
Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) Data	Pre-MMA MMA	Enrollee demographic information Type of complaint (e.g., access, quality of care, etc.) Plan enrollment
Medicaid Fair Hearing data	MMA	Date hearing requested Date hearing held Plan Name Service in Question Petitioner's Favor/Respondent's Favor
Managed Care Plans' Performance Improvement Projects (PIPs) and External Quality Review Organization (EQRO) Reports	MMA	Description and overall analyses of plan performance improvement projects (improvement strategies and data analyses) to improve HEDIS/Agency defined measures.
Managed Care Plans' Choice Materials and Managed Care Span	Pre-MMA	Plan benefit data

Data Source	Time Period*	Variables
	MMA	
Agency Quarterly and Annual Reports to CMS	MMA	Review of expanded services
Managed Care Plans' policies and procedures related to care coordination	Pre-MMA MMA	Review of policies and procedures related to care coordination
Timely Access PCP Wait Times Report	MMA	Average appointment wait times
Long-Term Care Case Management and Monitoring Reports	MMA	Case file audit reviews to determine the timeliness of enrollee assessments performed by case managers Reviews of the consistency of enrollee service authorizations performed by case managers Development and implementation of continuous improvement strategies to address identified deficiencies
Medicaid Choice Counseling Data	Pre-MMA MMA	Medicaid choice counseling data will be used to determine auto-enrollment, plan selection, and length of plan enrollment.
Florida Center for Health Information and Transparency Encounter Data	Pre-MMA MMA	All variables available in the inpatient hospital discharge, emergency department, and ambulatory surgery discharge data
MMA Managed Care Plans' reports on Healthy Behaviors programs	MMA	All available data related to each Healthy Behaviors program Caseloads (new and ongoing) for each Healthy Behaviors program at the individual recipient level Amount and type of rewards/incentives provided for each Healthy Behaviors program
Annual Milestone Statistics and Findings Report Data	MMA	LIP Payments by provider (hospital and non-hospital) Number of individuals served (hospital providers) including Medicaid, Uninsured, Total all unduplicated, Inpatient, Outpatient, and Inpatient/ Outpatient combined Average number of individuals served (hospital providers) Growth in the number of individuals served (hospital

Data Source	Time Period*	Variables
		providers) Number of encounters for specific services (hospital providers) including Medicaid, Uninsured/Underinsured, Hospital discharges, Hospital inpatient (days), Emergency care (encounters), ER visits, Hospital outpatient, Affiliated services (encounters), Prescription drugs `(number of prescriptions filled)
Florida Hospital Uniform Reporting System	DY11-DY16	This report collects financial and utilization statistics each year from Florida Hospitals.
Disproportionate Share Hospital Data	DY11-DY16	This data will be utilized as needed for uninsured and uncompensated care analyses. Note: There is presently a three-year lag in the availability of annual DSH survey data.
Medicare Cost Reports	DY11-DY16	This report includes descriptive, financial, and statistical data on hospitals and may be helpful with identifying facility characteristics, costs and charity care
Information on charity care programs including policies and criteria for all LIP funded hospitals.	DY11-DY16	Descriptive data on hospital charity care programs.
Qualitative data from interviews with health plan care coordination experts	MMA	Themes from qualitative interviews, specifically addressing: (1) care coordination strategies for enrollees needing behavioral health or non-emergency transportation services; (2) the most effective strategies for ensuring access to services; and (3) strategies for coordinating these services specifically for dual-eligible members; (4) strategies that standard MMA and Specialty MMA plans are using to improve quality of care and the strategies that are most effective; and (5) perceived care coordination effectiveness for enrollees who are homeless are at-risk for homeless
Enrollee satisfaction surveys: - behavioral health and non-emergency transportation services; - expanded benefits; - dental health services, including expanded dental health benefits.	MMA	Telephone surveys covering sociodemographic characteristics, health and functional status/needs, and experience and satisfaction with behavioral health services, non-emergency transportation services, expanded benefits, dental health services and expanded dental health service benefits.

Enrollee roster reports submitted by MMA plans to identify housing assistance services	MMA	Number of enrollees using transitional housing services, number of enrollees using mobile crisis services, number of enrollees using peer support services, number of enrollees using tenancy services
Department of Law Enforcement	MMA	Number of police contacts, number of arrests
Department of Corrections	MMA	Number of incarcerations

*Unless otherwise noted, Pre-MMA time period refers to SFYs 2011-12 and 2012-13. MMA time period refers to May 1, 2014 through the latest date when complete data is available.

6. Analytic Methods

This evaluation will employ both quantitative and qualitative methods in answering the research questions outlined above. The quantitative methods will include both simple descriptive methods and multivariable statistical methods while the qualitative methods will include analysis of structured administrative interview data and thematic analyses of semi-structured interview data (using content analyses and grounded theory).

The remainder of this section describes these methods in greater detail. Table 6 following these descriptions lists each research question along with the associated analytic method to be used in answering that question.

Overall Analytic Design Issues

Pre-post comparisons have well-known limitations concerning the influence of intervening factors beyond the intervention under study that can bias the observed treatment effect. Similarly, post-only comparisons face the challenge of unobserved heterogeneity between the treatment and comparison groups that influence both outcomes and selection into the treatment vs. comparison groups.

Unfortunately, evaluation designs such as difference-in-differences and propensity-score matching that address the limitations of pre-post and post-only designs are not feasible for evaluating Florida's MMA program. Florida's statewide transition to the MMA program took place over a three-month period[4] and included over 90 percent of Florida's Medicaid enrollees. This poses special challenges for employing evaluation designs such as difference-in- differences and propensity-score matching since no suitable comparison groups were available within Florida Medicaid following MMA implementation. Employing comparison groups outside of Florida Medicaid is problematic because such comparison groups will differ in systematic ways from Florida Medicaid enrollees. Such systematic differences will likely generate large pre-period treatment-comparison differences that will violate the parallel time trends assumption of difference-in-differences.

Given these constraints, this evaluation will employ pre-post- and post-only comparisons as dictated by the research question under study. In general, a pre-post perspective will be used when the focus is on the overall impact of the MMA intervention on costs and utilization. A post-only perspective will be used when the research question is focused on some aspect of the MMA program operation, such as separate vs. comprehensive MMA and LTC service organization. Multivariable statistical models will be used whenever feasible to control for other factors that might influence the outcome.

Statistical Testing and Modeling

Basic statistical tests (e.g., t-tests and chi-square tests) will be employed wherever possible to ensure that observed differences are not simply the results of random variation. However, such

[4] This three-month period covered virtually the full transition to the MMA program, although one MMA plan (Freedom) began operations in January 2015.

testing will not always be feasible since distributional measures for the data, standard deviation or variance, and enrollee sample sizes will not always be available from the statewide and plan-level data provided for various years. In such cases, it will not be possible to calculate the standard errors necessary for making statistical inferences, and therefore, the data will be presented as simple descriptive comparisons with brief comments.

Multivariable statistical models will be used when analyzing individual enrollee encounter cost and utilization data to control for factors that influence costs and utilization and isolate the effect of the characteristic under study (e.g., the MMA intervention and separate vs. comprehensive MMA and LTC services). The impact of factor under study (e.g., the MMA program) will be assessed using a two-part mixture model which first assesses the odds of having any expenditure or use using a random effects logit model (Equation 1) that accounts for clustering by month and by individual, and then uses a random effects log-linear generalized least squares regression (Equation 2) that also accounted for clustering by month and by individual. Both models assess the impact of the MMA program by including an indicator for whether or not the observation was from an individual enrolled in an MMA plan during the MMA study period. This shows the shift in the intercept associated with the MMA program (i.e., the average difference in PMPM expenditures or use between the pre-MMA and MMA periods). The two equations estimated used the following specifications:

$$\ln\left(\frac{(any\ \$=1)}{p(any\ \$=0)}\right)_{it} = MMA \cdot \beta 1 + \text{Age} \cdot \beta 2 + \text{Gender} \cdot \beta 3 + \text{Race} \cdot \beta 4 + \text{RiskScore} \cdot \beta 5 + \varepsilon it$$

$$\ln(PMPM\ \$)_{it} = MMA \cdot \beta 1 + \text{Age} \cdot \beta 2 + \text{Gender} \cdot \beta 3 + \text{Race} \cdot \beta 4 + \text{RiskScore} \cdot \beta 5 + \varepsilon it$$

Where $\ln\left(\frac{(any\ \$=1)}{(any\ \$=0)}\right)$ is the natural log of the odds of an individual having any expenditures in a given month, while ln(PMPM $) is the natural log of expenditures by an individual in any given month given that they incurred any expenditures. To obtain an estimate of the likely difference in expenditures due to the MMA program, average PMPM expenditures were predicted assuming all enrollees continued in the pre-MMA program using the multivariate models, and then average PMPM expenditures were calculated again to determine what PMPM expenditures would have been if the trend in expenditures had instead followed the trend observed in the MMA program.

The multivariate model specifications for the comparison of pre-MMA to specialty MMA plans and pre-MMA to standard MMA plans was essentially the same except only observations from specialty MMA plan enrollees were used to assess expenditures during the MMA period for the specialty MMA analysis while only observations from standard MMA plan enrollees during the MMA period were used for the standard MMA plan analysis.

Qualitative Analyses

Qualitative research questions in this evaluation are found in Components 1, 2, 6, 8, 9, and 10:

- ***RQ1E**: What strategies are standard MMA and specialty MMA plans using to improve quality of care? Which of these strategies are most effective in improving quality and why?*

- ***RQ 2D**: How do enrollees rate their experience and satisfaction with the expanded benefits that are offered by their health plan?*
- ***RQ 6B**: What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services and non-emergency transportation services for dual-eligible enrollees?*
- ***RQ 6C:** How do dual-eligible enrollees rate their experience and satisfaction with* the *delivery of care they receive related to behavioral health and non-emergency transportation services?*
- ***RQ 8J**: How do enrollees rate their experiences and satisfaction with the expanded benefits offered by their dental health plans?*
- ***RQ 9A**: How will eliminating or reducing retroactive eligibility change enrollment continuity?*
- ***RQ10E**: Is care coordination more effective for the study population as a result of the Housing Assistance Pilot Program?*

Methods

Qualitative interviews with MMA plan experts. Experts in quality of care (RQ1E) and care coordination (RQ6B) at each of the MMA plans will be identified to participate in in-depth interviews. Each plan's contract manager will assist the investigators in identifying and contacting the appropriate experts. Identified experts will receive an introductory email that includes: the purpose of the study, contact information of qualitative team personnel who can answer questions about the study or the request and assist with any technical issues. In addition, the email will notify experts that we would like to schedule a 30- to 60-minute telephone interview with them. To assist our team in preparing for the interview, the introductory email will include a form-fillable PDF document with preliminary questions addressing the topics to be covered in the interviews (described below). The MMA plan experts will be asked to prepare written responses to these questions and email the completed PDF form to the study team prior to their scheduled interview.

The research teams will develop qualitative interview guides with a list of questions relevant to Research Questions 1E and 6B, respectively, which will be asked of all MMA plans. All data collection tools will be reviewed by the Agency prior to administration. The interview guides will include questions for plans that also participate in the LTC program to address the role LTC case managers (RQ6B) have in addressing the respective topics. Before each MMA plan's scheduled telephone interview, the research teams will review: (1) the MMA plan's updated Policy and Procedure document(s) provided by the Agency related to quality of care and performance improvement (RQ1E) or coordination of behavioral health services and non-emergency transportation services (RQ6B); and (2) the MMA plan's written responses to the preliminary questions in PDF format. These reviews may generate follow-up questions and points of clarification tailored to each specific health plan, which will be added to the plan's telephone interview guide prior to the plan's scheduled interview. They also will help to streamline the interview process and minimize respondent burden.

Follow-up telephone interviews will be conducted with the same experts who were initially contacted and who provided the written PDF responses, or appropriate delegated individuals

who are knowledgeable in the areas of interest. In addition, participants may include other health plan experts in the interviews. Interviews will follow a qualitative, semi-structured format. Interviews will be conducted by trained qualitative interviewers by telephone (lasting 30 to 60 minutes), audio recorded and transcribed for coding and analysis.

The qualitative team that comprises researchers from UF, UAB and FSU will administer the interviews that are specific to their component areas.

Qualitative interview analysis. Qualitative research teams will use Atlas.ti (V8) or Nvivo to analyze interview transcripts produced for research questions RQ1E and RQ6C, following iterations of content analysis and grounded theory. For each research question, an initial codebook of priori themes will be developed based on the interview guide. Coding of transcripts will be conducted concurrently with data collection and reviewed in team meetings to ensure inter-rater reliability. Following grounded theory methods, reviewers will define codes for new themes that emerge in the analysis; as new codes are produced, the codebook will be updated and previously-coded transcripts will be back-coded to capture the new themes. After all MMA plan interviews have been completed and their transcripts coded, the research teams will conduct a content analysis to determine the most common themes and relevant co-occurrences among the themes. Based on findings of the content analysis, the research teams will conduct targeted queries to identify patterns in responses and exemplary quotes.

Member surveys. The research teams will design structured telephone surveys to be administered to MMA plan members, addressing experiences and satisfaction with expanded health plan benefits (RQ2D), coordination of behavioral health and non-emergency transportation for dual-eligible members (RQ6C), and expanded benefits offered by prepaid dental health plans (RQ8J). The surveys will be administered to MMA plan members (RQ2D, RQ8J) and dual-eligible MMA plan members (RQ6C) who were enrolled in an MMA standard or MMA specialty plan in the last 12 months. Sources of survey questions are specific to the research questions and described in the sections below. Additional questions may be developed by the research teams upon written approval of the Agency.

Telephone surveys will be conducted by trained interviewers by phone. Participants will have the option to complete the surveys in English or Spanish. Telephone survey data will be analyzed by the research teams using SPSS V23, SAS, or Stata.

Qualitative issues and approaches for specific questions.

Research Question 1E

In addition to plan document reviews and interviews with plan experts, this component will review the *2015-2016 Florida Annual Performance Improvement Project Validation Summary Report* produced by the Health Services Advisory Group to identify specific performance improvement projects (PIPs) offered by health plans. During the in-depth interviews, experts will be specifically asked about their own performance improvement projects, including associated indicator rates. In addition, during the in-depth interviews experts will be asked to comment on which projects are most effective at improving quality and why they are effective.

Research Question 2D

A random sample of MMA enrollees who used at least one expanded benefit during the previous 12 months will be included in this study.

Research Question 6B and 10E

Experts in care coordination at the MMA and MMA specialty plans will include individuals at all 11 MMA standard plans and 4 of the MMA specialty plans. Among the MMA standard plans, Amerigroup, Better Health, and Simply are owned by the same parent company (Anthem) and share the same policies and procedures; these three plans will therefore be considered as a single unit for analysis (i.e., only one "Anthem" interview will be conducted, covering Amerigroup, Better Health, and Simply). Among the six MMA specialty plans, two will be excluded because they are specific to children and do not cover the dual-eligible population of interest in this study (Children's Medical Services and Sunshine Child Welfare). The remaining four MMA specialty plans (Clear Health Alliance, Freedom Health, Magellan Complete Care, and Positive Health) will be included in this study. A total of 13 health plan units will be included in the analysis.

Research Question 6C

A stratified random sample of dual-eligible survey respondents will be selected from the populations of adult dual-eligible enrollees (18+ years) who were continuously enrolled in the same MMA standard plan (Group 1) or MMA specialty plan (Group 2) during the 12 months prior to sampling.

The survey tool to be administered for research question 6C may include: (1) items from the CAHPS Health Plan Survey for Medicaid, Version 4.0 supplemental set addressing health plan transportation, (2) the Experience of Care and Health Outcomes (ECHO) Survey – a validated survey tool from the Agency for Healthcare Research and Quality that assesses experiences with behavioral health care, (3) other questions on non-emergency transportation provided in correspondence with AHCA, and (4) questions from the Medicare Health Beneficiary Survey to collect information on self-reported health and functional status for dual-eligible members. The survey will have the option to be completed by sampled members or (in cases where the member is physically or mentally unable to participate) by proxy respondents (such as family members) who are familiar with the member's health and health care.

Research Question 8J

Sampling and other survey methods specific to RQ 8J will likely be similar to those used for RQs 2D and 6C, and will be determined after more information on the operation and utilization rates of the prepaid dental health program becomes available.

Research Question 9A

RQ 9A proposes to survey hospital and nursing facilities to determine their changes in enrollment application procedures following or in anticipation of the change in retroactive enrollment policy. Sampling and other survey methods for RQ 9A will likely be similar to those used for RQ 1E.

Table 12. Design Table for the Evaluation of the Demonstration

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Component 1: The effect of managed care on access to care, quality and efficiency of care, and the cost of care				
1A. What barriers do enrollees encounter when accessing primary care and preventive services?	-Frequencies of complaints, grievances, and appeals related to access to care	-MMA enrollees reporting complaints, and issues to (1) the Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) or (2) individual plan reports of complaints, grievances, and appeals	-Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) data -Plan data on frequencies of complaints, grievances, and appeals related to access to care -Medicaid Fair Hearing data	-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to access to primary care and preventive services
1B. What changes in the accessibility of services occur with MMA implementation, comparing accessibility in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to MMA plans?	-**Standard measures and composites of the CAHPS survey:** -Getting Needed Care -Getting Care Quickly -Rate the Number of Doctors -Health Plan Information and Customer Service - **MMA program weighted HEDIS means:**	-MMA program as a whole compared to Reform and 1915 (b) waiver plans utilizing CAHPS data -MMA program weighted HEDIS means compared to the weighted means for Reform and 1915 (b) waiver plans prior to implementation of the MMA program	-CAHPS, HEDIS, encounter data as necessary	-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to accessibility of services

	-Adolescent Well-Care Visits -Adults' Access to Preventive/Ambulatory Health Services (20-44 years, 45-64 years, 65+ years, Total) -Breast Cancer Screening -Cervical Cancer Screening -Childhood Immunization Status (Combo 2, Combo 3)			

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	-Children and Adolescents' Access to Primary Care Practitioners (12-24 months, 25 mos-6 years, 7-11 years, 12-19 years) -Chlamydia Screening in Women (16-20 years, 21-24 years, Total) -HIV-Related Outpatient Medical Visits (2 visits ≥182 days apart) -Immunizations for Adolescents (Combo 1) -Lead Screening in Children -Prenatal and Postpartum Care (Timeliness of Prenatal Care, Postpartum Care) -Frequency of Ongoing Prenatal Care/Prenatal Care Frequency (≥ 81% of expected visits) -Transportation Availability -Well-Child Visits in the First 15 Months of Life (0 visits, 6+ visits) -Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			

1C. What changes in the utilization of services for enrollees are evident post MMA implementation, comparing: 1) utilization of services in the pre-MMA period (FFS, Reform plans, and pre-MMA 1915(b) waiver plans) to	Utilization: - Inpatient -Outpatient -ED -Professional (Physician, Specialist)	-Pre-MMA vs. MMA periods -Enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in specialty plans	-Medicaid claims, eligibility, enrollment, encounter data	-Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
utilization of services in post MMA implementation; 2) utilization of services in specialty MMA plans versus standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in the specialty plans?				

1D. What changes in quality of care for enrollees are evident post MMA implementation, comparing: 1) quality of care in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to quality of care in MMA plans in the MMA period; and 2) quality of care in specialty MMA plans vs. standard MMA plans for enrollees eligible for enrollment in a specialty plan (e.g., enrollees with HIV or SMI) who are enrolled in standard plans vs. enrollees in specialty plans (to the extent possible)?	-**Standard measures and composites of the CAHPS survey**: -Overall Rating of Health Plan -Overall Rating of Health Care -Shared Decision-Making -Overall Rating of Personal Doctor -Overall Rating of Specialist -**MMA program weighted HEDIS means**: -Adolescent Well-Care Visits -Childhood Immunization Status (Combo 2 , Combo 3) -Children and Adolescents' Access to Primary Care Practitioners (12-24 mos, 25 mos-6 yrs, 7-11 yrs, 12-19 yrs) -Chlamydia Screening	-MMA program as a whole compared to Reform and 1915 (b) waiver plans utilizing CAHPS data -Enrollees eligible for enrollment in a specialty plan (e.g. enrollees with HIV or SMI) who are enrolled in standard MMA plans versus enrollees in specialty plans	-Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey data -HEDIS, Child and Adult Core Set measures, and Agency-defined performance measures	-Descriptive statistics and t-test. Analyze overall ratings variables related to satisfaction with health care, health plan, shared decision-making, personal doctor, and specialists

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	in Women (16-20 yrs, 21-24 yrs, Total) -HIV-Related Outpatient Medical Visits (2 visits ≥182 days apart) -Immunizations for Adolescents (Combo 1) -Lead Screening in Children -Well-Child Visits in the First 15 Months of Life (0 visits, 6+ visits) -Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life -Adult BMI Assessment -Antidepressant Medication Management (Acute, Continuation) -Comprehensive Diabetes Care (HbA1c Testing, HbA1c Good Control, HbA1c Poor Control, Eye Exam, Nephropathy, LDL-C Screening, LDL-C Control) -Controlling High Blood Pressure -Follow-up After Hospitalization for a Mental Illness (7 day, 30 day) -Follow-up Care for Children Prescribed ADHD Medication (Continuation, Maintenance) -Highly Active Anti-Retroviral Treatment			

	-Mental Health Readmission Rate -Medication Management for People with Asthma (50% and 75% medication			

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	compliance)			
1E. What strategies are standard MMA and specialty MMA plans using to improve quality of care? Which of these strategies are most effective in improving quality and why?	-Descriptions of Performance Improvement Projects (PIPs), including their objectives, interventions, and outcomes -Themes from qualitative interviews with plan experts on quality of care	-Standard plan populations -Specialty plan populations -Populations outlined in PIPs - Representatives of MMA and MMA specialty plans	-EQRO reports and plan PIPs as available. -Qualitative Interviews	-Descriptive analyses -Qualitative analyses (interviews with health plan Quality Improvement contacts)
1F. What changes in timeliness of services occur with MMA implementation, comparing timeliness of services in pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) to post-MMA implementation plans?	-Standard measures and composites of the CAHPS survey: -Getting Care Quickly -Average PCP appointment wait times for urgent care, routine sick visits, and well care visits -MMA program weighted HEDIS and other performance measure means: -Prenatal and Postpartum care (Prenatal, Postpartum) -Transportation Timeliness	-MMA program as a whole compared to Reform and 1915 (b) waiver plans for CAHPS timeliness of services data -Pre-MMA implementation plans (Reform plans and 1915(b) waiver plans) and post-MMA implementation plans -Comparison of Florida MMA program weighted means to Medicaid National Means and Percentiles for HEDIS measures	-CAHPS (Adult and Child): Getting Care Quickly survey measure -Timely Access PCP Wait Times report -HEDIS measures related to timeliness of services -Agency defined measure related to transportation timeliness	-Descriptive statistics and t-test. Analyze overall ratings variables related to enrollee perceptions of timeliness of services (e.g., getting care quickly, timeliness of prenatal care, postpartum care and transportation timeliness)

1G. What is the difference in per-enrollee cost by eligibility group pre-MMA implementation (FFS, Reform plans and pre-MMA 1915(b) waiver plans) compared to per-enrollee costs in the MMA period (MMA plans as a whole, standard	-Per-member per-month expenditures as measured by monthly risk-adjusted capitated payment to plans	-Pre-MMA beneficiaries enrolled in FFS, Reform and 1915 (b) waiver plans at any point in time during DY8 -Beneficiaries in MMA plans at any point in time during DY9- DY16	-Medicaid FFS and capitation claims, Medicaid eligibility data	-Univariate analysis -Multivariate regression and interrupted time series analyses (as appropriate) to assess PMPM expenditures before and after implementation of the MMA program as well as across

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
MMA plans and specialty MMA plans)?				standard MMA and specialty MMA plans. Evaluators will examine trends in PMPM expenditures over time. Multivariate controls will include age, gender, risk score, and race/ethnicity
Component 2: The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care				
2A. What is the difference in the types of expanded benefits offered by standard MMA and specialty MMA plans? How do plans tailor the types of expanded benefits to particular populations?	-Descriptive statistics of plan benefits over time, including the number of expanded benefits offered per plan, as well as the average number of expanded benefits across plans, for both specialty and standard MMA plans	-Standard and specialty plans that offer expanded benefits	-Health plan choice materials and Agency quarterly and annual reports to Federal CMS; evaluators will use these data sources to identify any expanded/additional services plans cover -Other health plan benefit data as identified	-Descriptive analyses
2B. How many enrollees utilize expanded benefits and which ones are most commonly used?	-Number of enrollees that use expanded benefits. -Expanded benefits that are used most frequently by enrollees.	-Users of expanded benefits	-Encounter data -Data on the types of expanded benefits offered by each plan.	-Descriptive analyses

2C. How does Emergency Department (ED) and inpatient hospitalization differ for those enrollees who use expanded benefits (e.g., additional vaccines,	-ED utilization -Inpatient hospitalizations	-Users of expanded benefits vs non-users of expanded benefits	-Encounter data	-Multivariate analyses, when applicable & to the extent possible

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
physician home visits, extra outpatient services, extra primary care and prenatal/perinatal visits, and over-the-counter drugs/supplies) vs. those enrollees who do not?				
Beginning with the evaluation of DY11 (SFY 2016-17) **2D.** How do enrollees rate their experiences and satisfaction with the expanded benefits that are offered by their health plan?	-Enrollee satisfaction with expanded benefits	-Health plan enrollees	-Surveys	-Qualitative analyses
Component 3: Participation in the Healthy Behaviors programs and its effect on participant behavior or health status				
3A. What Healthy Behaviors programs do MMA plans offer? What types of programs and how many are offered in addition to the three required programs (medically approved smoking cessation program, the medically directed weight loss program, and the medically approved alcohol or substance abuse treatment program)?	-Types and number of Healthy Behaviors programs	-MMA standard and specialty plans	-MMA managed care plan reports on healthy behaviors	-Descriptive analyses
3B. What incentives	-Incentives and	-MMA	-MMA managed	-Descriptive

and rewards do MMA plans offer to their enrollees for participating in	rewards offered by the plans to enrollees participating in HB programs.	standard and specialty plans	care plan reports on healthy behaviors.	analyses

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Healthy Behaviors programs?				
3C. How many enrollees participate in each Healthy Behaviors program? How many enrollees complete Healthy Behaviors programs? Which types of Healthy Behaviors programs attract higher numbers of participants? **3D.** How does participation in Healthy Behaviors programs vary by gender, age, race/ethnicity and health status of enrollees? (evaluation of DY13 SFY 2018-19 and beyond, upon receipt of individual-level Healthy Behaviors data)	-Healthy Behaviors enrollees (gender, age) -Healthy Behaviors enrollees (race/ethnicity, health status beginning with the evaluation of DY13 – SFY 2018-19) -Healthy Behaviors program types -Service utilization (evaluation of DY13 and beyond)	-Healthy Behaviors program enrollees	-Healthy Behaviors plan summary reports, quarterly -Individual data, DY13 and beyond	-Descriptive analyses -Multivariate analyses for 3E, DY13 and beyond

3E. What differences in service utilization occur over the course of the demonstration for enrollees participating in Healthy Behaviors programs versus enrollees not participating? (evaluation of DY13 and beyond, upon receipt of individual-level Healthy Behaviors data)				

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Component 4 : The impact of LIP funding on hospital charity care programs				
For the evaluation of DY10 (SFY 2015-16) only **4A.** What is the impact of LIP funding on access to care for Medicaid, uninsured, and underinsured recipients served in hospitals? That is, how many Medicaid, uninsured, and underinsured recipients receive services in LIP funded hospitals?	-Number of uninsured/underinsured patient served in LIP funded hospitals in DY10	-Hospitals that received LIP funding in DY10	-LIP providers -Payment amounts and type of payments (category) made to each provider. -"Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured	-Descriptive statistics and univariate analyses as applicable and to the extent possible
4B. What types of services are being provided to Medicaid, uninsured, and underinsured recipients receiving care in LIP funded hospitals?	-Number and types of services provided to uninsured/underinsured patients served in LIP funded hospitals in DY10	-Hospitals that received LIP funding in DY10	- LIP providers -"Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured	-Descriptive statistics and univariate analyses as applicable

Beginning with the evaluation of DY11 (SFY 2016-17) **4C.** What is the impact of LIP funding on access to care for uncompensated charity care recipients served in hospitals? That is, how many	-Volume of services provided to uninsured patients: adjusted days (total inpatient days adjusted by patient-care revenues for outpatient services) -Dollar amount of charity care provided: gross revenue, net revenue, operating expense	-All organizations receiving LIP funding beginning with the evaluation of DY11	-FHURS data: annual financial and utilization statistics for hospitals (include gross revenues & net revenues for uncompensated care patients, and operating expenses) -LIP data: LIP	-Descriptive statistics and univariate analyses as applicable

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
uncompensated charity care recipients receive services in LIP funded hospitals? How does this compare among hospitals in different tiers of LIP funding? **4D.** What types of services are being provided to uncompensated charity care recipients receiving care in LIP funded hospitals? **4E.** What is the difference in the type and number of services offered to uncompensated charity care patients in hospitals receiving LIP funding?			providers -Payment amounts and type of payments (category) made to each provider -LIP funding tiers including the specific organizations included in each tier -"Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured -Medicare cost reports -DSH reporting data as available -Information on hospital charity care programs (policies, procedures, descriptions etc.)	

Beginning with the evaluation of DY12 (SFY 2017-18) **4F.** What is the impact of LIP funding on the number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical	-Number of uncompensated charity care patients served -Types of services provided for each provider within each provider type category	-LIP funded FQHCS, RHCs, and medical school physician practices	-Number of uncompensated charity care patients served and the types of services provided in FQHCs, RHCs, and medical school physician practices -FHURS data: annual financial and utilization statistics for hospitals (include gross revenues & net	-Descriptive and univariate analyses, to the extent possible

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
school physician practices?			revenues for uncompensated care patients, and operating expenses) -Payment amounts and type of payments (category) made to each provider -LIP funding tiers including the specific organizations included in each tier -"Annual Milestone Data": number of uncompensated care/uninsured patients served, types and number of uncompensated care services and encounters provided to the uninsured -Medicare cost reports -DSH reporting data as available	
Component 5: The effect of having separate managed care plans for acute care and LTC services on access to care, care coordination, quality, efficiency of care, and the cost of care (This Component will sunset following the evaluation of DY12 – SFY 2017-18)				

5A. How many enrollees are enrolled in separate Medicaid managed care programs for acute (medical) care and LTC services? **5B**. How many enrollees are enrolled in comprehensive	-Enrollment numbers -Service utilization and cost per enrollee per year	-Medicaid enrollees in separate acute and LTC plans -Enrollees in comprehensive plans that provide both acute and LTC services	-Enrollment data -FL Hospital Discharge, ambulatory surgery visit and emergency department visits data -Medicaid claims and encounter data	-Descriptive statistics -Multivariate analysis

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
plans that provide both acute (medical) care and LTC services? **5C.** Are there differences in service utilization, as well as in the appropriateness of service utilization (to the extent this can be measured), between enrollees who are in a comprehensive plan for both MMA and LTC services versus those who are enrolled in separate MMA and LTC plans?		-Service utilization and costs	-Capitation payment data	
Component 6: The impact of efforts to align with Medicare and improving beneficiary experiences and outcomes for dual eligible individuals				

6A. How many MMA enrollees are also Medicare recipients (dual-eligibles) and to what extent do dual-eligible enrollees utilize behavioral health and non-emergency transportation services? **6B.** What specific care coordination strategies and practices are most effective for ensuring access to and quality of care for behavioral health services and non-emergency transportation services for dual-	-Enrollee counts (6A) -Content analysis results for plans' care coordination practices related to behavioral health and non-emergency transportation services -Qualitative themes from interviews with plan experts on care coordination -CAHPS measures of experience and satisfaction with delivery of non-emergency transportation services; and ECHO measures of experience and satisfaction with	-Representatives of MMA and MMA specialty plans (care coordination experts) -Dual-eligible members in MMA and MMA specialty plans	-Medicaid encounter, eligibility, and enrollment data -Florida Health Data Center hospital and emergency department encounter data for dual-eligibles receiving care under Medicare auspices -MMA and MMA specialty plan P&P documents on coordination of behavioral health and non-emergency transportation services	-Descriptive analysis -Qualitative analysis using Atlas Ti, grounded theory and content analysis for plan care coordination experts -Descriptive analysis of telephone interview data

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
eligible enrollees? **6C.** How do dual-eligible enrollees rate their experience and satisfaction with delivery of care they received related to behavioral health and non-emergency transportation services?	behavioral health services		-Follow up Qualitative Interviews -Medicaid eligibility and enrollment data for telephone interview-eligible sample pool of dual-eligibles -Telephone survey results (frequencies for response categories for each question)	
Component 7: The effectiveness of enrolling individuals into a managed care plan upon eligibility determination in connecting beneficiaries with care in a timely manner				
7A. How quickly do new enrollees access services, including expanded benefits in excess of State Plan covered benefits, after becoming Medicaid eligible and enrolling in a health plan? **7B.** Among new enrollees, what is the time to access services for enrollees who are enrolled under express enrollment compared to enrollees who were enrolled prior to the implementation of express enrollment?	-Time to access services from enrollment date to date of first service use	New MMA enrollees (7A, 7B) New Medicaid enrollees in pre-MMA HMO and PSN plans in DY7 (7B) -New MMA enrollees who selected their MMA plan (7A) -New MMA enrollees who were auto-enrolled in an MMA plan (7A) -New MMA enrollees who switched plans within 120 days of initial enrollment (7A)	-Eligibility and Encounter data -Enrollment data that indicates auto-enrolled vs. enrollee-selected and whether the enrollee switched plans within 120 days	-Descriptive statistics and t-tests as applicable

		-New MMA enrollees who did not switch plans within 120 days of initial enrollment (7A)		

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
Component 8: The effect the Statewide Medicaid Prepaid Dental Health Program has on accessibility, quality, utilization, and cost of dental health care services				
8A. How does enrollee utilization of dental health services vary by age, gender, race/ethnicity, and geographic area? **8B.** What changes in dental health service utilization occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program (PDHP)?	Dental Utilization: - Inpatient -Outpatient -ED -Professional (Physician, Specialist)	-Pre-PDHP period for the two SFYs immediately preceding SMPDHP implementation -PDHP period for SFYs following establishment of prepaid dental program -Enrollees eligible for enrollment in a prepaid dental plan	-Medicaid claims, eligibility, enrollment, encounter data for dental services	-Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the extent possible), and race/ethnicity.
8C. What changes in quality of dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	-**Dental performance measures listed in Table 3:** -Annual Dental Visit -Dental Treatment Services -Sealants for 6-9 Year-old Children at Elevated Caries Risk - Preventive Dental Services **The following four performance measures were not reported by plans prior to PDHP:** -Oral Evaluation -Topical Fluoride for Children at Elevated Caries Risk	-Pre-PDHP period for the two SFYs immediately preceding PDHP implementation -PDHP period for SFYs following establishment of prepaid dental program -Enrollees eligible for enrollment in a prepaid dental plan	-PDHP performance measure reports to the Agency	-Univariate analyses of temporal changes in dental quality measures using statistical tests of changes

	-Ambulatory Care Sensitive Emergency Department Visits for			

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	Dental Caries in children -Follow-up after Emergency Department Visits for Dental Caries in Children			
8D. What changes in the accessibility of dental services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	**-Measures from CAHPS Dental Survey related to Access to Services (see Table 3):** -Percentage of respondents reporting their dental appointments are usually or always as soon as they want (vs. sometimes or never) -Percentage of respondents reporting they usually or always get an appointment with their dental specialist as soon as they want (vs. sometimes or never) -Percentage of respondents reporting they usually or always spend 15 minutes or less in the waiting room before seeing someone for their appointment (vs. sometimes or never)	-PDHP program CAHPS access to care results examined over time	-CAHPS data described in Table 3	-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to accessibility of services

	-Percentage of respondents reporting someone usually or always tells them why there is a delay or how long the delay will be if they have to wait more than 15 minutes in the waiting room before being seen for an			

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
	appointment (vs. sometimes or never) -Percentage of respondents answering "somewhat yes" or "definitely yes" when asked whether they get to see a dentist as soon as they want if they have a dental emergency (vs. "somewhat no" or "definitely no")			
8E. What barriers do enrollees encounter when accessing dental health services?	-Frequencies of complaints, grievances, and appeals related to access to care for dental services	- Statewide Medicaid Prepaid Dental Health Program enrollees reporting complaints, and issues to (1) the Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) or (2) individual plan reports of complaints, grievances, and appeals	-Agency Complaints, Issues, Resolutions & Tracking System (CIRTS) data -Dental plan data on frequencies of complaints, grievances, and appeals related to access to care -Medicaid Fair Hearing data	-Descriptive statistics and t-tests as applicable. Analyze overall ratings variables related to access to primary care and preventive services
8F. How many enrollees utilize expanded benefits provided by the dental health plans and which ones are most commonly used?	- Number of dental plan enrollees that use expanded dental benefits -Expanded dental benefits that are used most frequently by dental enrollees	-Users of expanded dental benefits	-Dental encounter data -Data on the types of expanded benefits offered by each dental plan.	-Descriptive analyses

8G. How does enrollee utilization of dental health services impact dental-related hospital events (e.g., Emergency Department, Inpatient hospitalization)?	-Medicaid dental encounter records for dental plan enrollees merged by Medicaid enrollee ID with MMA encounter records for hospital ED and inpatient use -Rates of dental service	-Statewide Medicaid Prepaid Dental Health Program enrollees who also use MMA services	-Medicaid dental and medical encounter data, eligibility, enrollment, encounter data	-Univariate analysis -Multivariate analysis. Multivariate controls will include age, gender, health status (to the

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
How does utilization of expanded benefits offered by the dental health plans impact dental-related hospital events?	utilization and associated dental-related hospitalizations			extent possible), and race/ethnicity
8H. What changes in per-enrollee cost for dental health services occur with the implementation of the Statewide Medicaid Prepaid Dental Health Program?	-Per-member per-month expenditures as measured by monthly risk-adjusted capitated payment to plans	-Pre-PDHP beneficiaries enrolled in FFS, Reform and 1915 (b) waiver plans at any point in time during pre-PDHP period -PDHP beneficiaries in dental plans following PDHP roll-out	-Medicaid FFS and capitation claims related to dental services -Medicaid and dental eligibility data	-Univariate analysis -Multivariate regression and interrupted time series analyses (as appropriate) to assess PMPM expenditures before and after implementation of the PDHP program. Evaluators will examine trends in PMPM expenditures over time. Multivariate controls will include age, gender, risk score, and race/ethnicity
8I. How do enrollees rate their experiences and satisfaction with dental health services, including timeliness of dental health services, provided by their dental health plans?	-CAHPS dental survey measures as listed in this table for Question 8D	-PDHP program as a whole	-CAHPS Dental Services Survey	-Descriptive statistics and t-test. Analyze overall ratings variables related to enrollee perceptions of timeliness of services
8J. How do enrollees rate their	-Enrollee satisfaction with expanded benefits	-PDHP plan enrollees	-Surveys	-Qualitative analyses

experiences and satisfaction with the expanded benefits offered by their				

Research Question	Outcome Measures Used	Sample or Population Subgroups Compared	Data Sources	Analytic Methods
dental health plans?				
Component 9: The impact of the waiver of retroactive eligibility on beneficiaries and providers.				
Note on Difference-in-Differences (D-i-D) and Regression Discontinuity Approaches: The retroactive enrollment policy change was implemented at a single point in time for all adult enrollees except pregnant women, making identifying an appropriate comparison group virtually impossible and preventing the use of DiD. In addition, retroactive enrollment eligibility was not based on a fixed, precise cutoff score, thereby preventing a regression discontinuity approach. For these reasons, we are proposing to use a pre-post comparison approach to addressing Component 9's research questions and hypotheses, using appropriate covariates to control for possible confounding.				
9A. How will eliminating or reducing retroactive eligibility change enrollment continuity?	-Enrollment duration in months for Medicaid cohorts both before and after the policy change -Qualitative information on how hospitals and nursing facilities have changed their enrollment procedures following or in anticipation of the policy change	-Enrollment duration for (1) Medicaid enrollee cohort as of January 2019 (last month prior to policy change) and (2) Medicaid enrollee cohort as of last month available after the policy change	-Medicaid eligibility and enrollment data -Qualitative results of surveys/interviews of hospital and nursing facility administrators	-Pre-post duration models of enrollment length (e.g., Cox proportional hazards model or accelerated failure time model) -Qualitative methods (open-ended surveys and/or key informant interviews)
9B. How will eliminating or reducing retroactive eligibility change the enrollment of eligible people when they are healthy relative to those eligible people who have the option of retroactive eligibility?	-Clinical Risk Groups (CRGs) (Averill et al., 1999; Hughes et al., 2004), a widely-used measure of health status calculated from claims and encounter data	-New Medicaid enrollees	-Medicaid encounter data for new enrollees completing their first year of enrollment both before and after the policy change	-Difference-in-differences testing (if possible) or pre-post statistical models of the distribution of new Medicaid enrollees across the five major CRG categories both before and after the policy change -The evaluation team will also explore administering the SF-12 tool using a telephone survey of new enrollees following the policy change to measure health status. Comparing health status as measured by the CRGs to health

				status as measured by the SF-12 will help validate the broader application of the CRGs in RQ 9B
9C. How will eliminating or reducing retroactive eligibility affect new enrollee financial burden?	-Hospital utilization and charges with self-pay payor status from the three-months prior to Medicaid application date both before and after the policy change	-New Medicaid enrollees	-Linked (1) statewide Florida Health Information and Transparency (FHIT) Center hospital inpatient, outpatient, ambulatory, and ED utilization data, (2) Medicaid new enrollee encounter data both before and after the policy change for the three months prior to Medicaid application date	-Pre-post testing of self-pay utilization and charges in the three-months prior to Medicaid application using linked encounter data both before and after the policy change. In particular, self-pay charges will measure the amount of health care charges previously covered by Medicaid under retroactive eligibility that will now fall to the self-pay patient and/or provider uncompensated care. The evaluation team will also examine Medicaid FFS and Medicaid MMA payor classes
Note: Results from 9C will determine whether 9D through 9F are applicable.				
9D. How will eliminating or reducing retroactive eligibility affect provider uncompensated care amounts?	-Hospital and SNF Uncompensated Care Expenditures -Hospital and SNF net income and rates of return	-Florida hospital and SNFs serving Medicaid enrollees Florida hospital and SNFs serving Medicaid enrollees	-Florida Hospital Uniform Reporting System (FHURS) -CMS Medicare Hospital and SNF Cost Reports -Florida Low Income Pool expenditure reports	-Difference-in-Differences models (if possible) or pre-post statistical models examining uncompensated care amounts, net income/rates of return, and uncompensated care net of LIP payments
9E. How will eliminating or reducing retroactive eligibility affect provider financial performance (income after expenses)?	-Hospital net change impact of UCC: UCC – LIP payments Hospital and SNF Uncompensated Care Expenditures			
9F. How will eliminating or reducing retroactive eligibility affect the net financial impact of uncompensated care (UCC – LIP payments)?	-Hospital and SNF net income and rates of return			

	-Hospital net change impact of UCC: UCC – LIP payments			
Component 10: The impact of the behavioral health and supportive housing assistance pilot on beneficiaries who are 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, and are homeless or at risk of homelessness due to their disability.				
10A. How many MMA plans participate in the Housing Assistance Services pilot program? How many enrollees are participating in the housing assistance services program, by plan? How does participation in the housing assistance services program vary by gender, age, race/ethnicity and health status of enrollees?	-Total number of participating MMA plans -Total number of enrollees receiving housing assistance services per plan -Total number of enrollees receiving housing assistance services by gender, age, race/ethnicity -Total number and type of services and diagnosis code(s) each enrollee had one year prior to entering the program and while in the program	-MMA enrollees receiving housing assistance services	-Enrollee Roster Report submitted by MMA plans	-Descriptive statistics (means, medians, standard deviations, etc.)
10B. What is the frequency and duration of use for the specific services (transitional housing services, mobile crisis services, peer support, tenancy services) offered by the housing assistance program by plan? What is the proportion of enrollees who are successfully discharged from the pilot but subsequently become homeless again and resume using services?	-Total number of enrollees using transitional housing services -Total number of enrollees using mobile crisis services -Total number of enrollees using peer support -Total number of enrollees using tenancy services	-MMA enrollees receiving housing assistance services	-Enrollee Roster Report submitted by MMA plans	-Descriptive statistics (means, medians, standard deviations, etc.)
10C. Based on Medicaid data submitted by the MMA plans, do enrollees in the study population have fewer avoidable hospitalizations and emergency department visits than they did prior to receiving	-Total number of potentially preventable hospitalizations per enrollee -Total number of potentially preventable emergency department visits per enrollee	-MMA enrollees with a diagnosis of SMI and homeless or at risk of being homeless	-Medicaid claims, eligibility, enrollment and encounter data -Hospital Discharge Data (FL Center) -Enrollee Roster Report submitted by MMA plans to identify housing assistance	-Difference-in-difference multivariate analyses comparing changes in utilization rates between the population enrolled in MMA plans offering housing assistance services who are participating in the pilot program and enrollees in the same MMA plans who are eligible for the

housing assistance services?			services that were provided	pilot program but are placed on a waiting list and are not yet participating in the pilot program
10D. Are there changes in utilization of MMA services (specifically PCP visits, Outpatient visits, pharmacy services and behavioral health services) in the study population compared to their service utilization prior to participation in the Pilot program?	-Total number of PCP visits per enrollee -Total number of outpatient visits per enrollee -Total number of pharmacy claims per enrollee -Total number of behavioral health service visits per enrollee	-MMA enrollees with SMI who are homeless or at risk of being homeless	-Medicaid claims and encounter data, specifically looking at utilization of PCP visits, outpatient visits, pharmacy services and behavioral health services	-Difference-in-difference multivariate analyses comparing changes in utilization rates between the population enrolled in MMA plans offering housing assistance services who are participating in the pilot program and enrollees in the same MMA plans who are eligible for the pilot program but are placed on a waiting list and are not yet participating in the pilot program
10E. Based on interviews with MMA plan staff, including Care Coordinators, is care coordination more effective for the study population as a result of the Pilot program?	-Qualitative assessment of care coordination effectiveness before and after implementation of the Pilot program	-MMA plan staff with knowledge of care coordination conducted by the plan	-Qualitative data based on survey responses to a Vendor-created survey of MMA staff, including Care Coordinators	-Descriptive statistics
10F. What are the effects of housing on reductions in police interactions, arrests, and incarcerations?	-Total number of police contacts -Total number of arrests -Total number of incarcerations	-Enrollees with SMI who are homeless or at-risk of homeless	-Department of Law Enforcement data -Department of Corrections	- Descriptive statistics (means, medians, standard deviations, etc.)

D. Methodological Limitations

Limitations of the evaluation include the design, the data sources or collection process, analytic methods and the state's efforts to minimize the limitations. Additionally, this section includes information about features of the demonstration that effectively present methodological constraints the state would like CMS to consider in its review.

- Current and subsequent years will continue to show that the MMA demonstration remains non-complex and mostly unchanged; therefore, evaluation results may be limited in providing additional or divergent findings from prior evaluations. In addition, the MMA program continues to operate smoothly without administration changes, with minimal appeals and grievances, and with no known issues with CMS 64 reporting or

budget neutrality. Consequently, the new STCs were modified to simplify and streamline the state's reporting requirements to CMS, moving from quarterly to annual reporting. In addition, monthly calls with CMS are now on a periodic basis as the need is determined.

- Individual level Healthy Behaviors data will be available beginning with the evaluation of DY13. However, the lack of individual level Healthy Behaviors data for the evaluations of DY10, DY11 and DY12 is a limitation because service utilization patterns will not be known for specific enrollees. For example, it will not be possible to know if participation in the program results in more appropriate use of services if the ability to link to individual enrollment, encounter and claims data is not possible.

Also, responses from dual-eligibles to telephone interviews concerning their assessments of their health care may unavoidably reflect a combination of Medicare and Medicaid experiences for behavioral health services.

Florida implemented the MMA program statewide over a period of three months and enrolled the great majority of Florida Medicaid recipients into MMA at that time. Consequently, there does not exist an appropriate comparison group within Florida Medicaid following the implementation of the MMA program. This poses major issues for conducting either a difference-in-differences or propensity score matching analysis. Difference-in-differences analysis requires data on both treatment and comparison groups both prior to and subsequent to the implementation of the MMA program. Florida's shift of the vast majority of its Medicaid recipients into the MMA program over a very short period of time precludes identifying a comparison group from within Florida Medicaid post-implementation. While other groups (e.g., the privately insured in Florida or other states' Medicaid enrollees) could furnish a comparison group, such diverse groups are likely to violate the parallel slopes assumption of difference-in- differences since they will be subject to different spatial and temporal trends than MMA enrollees.

Using such heterogeneous groups for propensity score matching to the MMA population poses similar challenges since such groups have intrinsic differences in geographical location and insurance coverage provisions that cannot be controlled through matching.

A major limitation in evaluating retroactive enrollment (Component 9) is the inability to identify enrollees after the policy change who would have been eligible for retroactive enrollment under the rules in effect prior to the policy change. The Agency estimates that only a small percentage of new Medicaid enrollees qualified for retroactive enrollment prior to the policy change. Consequently, any effect of the policy change on current new enrollees who would have qualified for retroactive enrollment under the previous policy will be difficult to capture among the large number of current new enrollees who would have been ineligible for retroactive enrollment under the previous policy.

Another challenge for the retroactive enrollment evaluation is the necessity to merge Medicaid enrollment records with Florida Health Data Center statewide inpatient discharge and ambulatory and ED visit data to capture the utilization of new Medicaid enrollees in the three months prior to Medicaid application. While such a merge should be possible given common

identifiers in the datasets, such a merge has not been attempted previously to the best of our knowledge and the match rate is therefore unknown.

A possible limitation for supportive housing (Component 10) for question 10F: "What are the effects of housing on reductions in police interactions, arrests, and incarcerations?" will be the availability of the FDLE and DOC data.

E. Attachments

1) Independent Evaluator.

Upon receipt of letters of intent and review of proposals submitted by two universities in 2015, the Agency determined that the University of Florida's (UF) proposals best fit the Agency's needs. Subsequently, in 2016, the Agency contracted with UF, located in Gainesville, FL, to conduct an independent evaluation of the MMA program. UF subcontracts with two other universities to conduct some components of the evaluation (Florida State University and University of Alabama at Birmingham). The Agency provided the evaluators with a description of the objectives of the MMA program and the approved evaluation design.

The Principal Investigator for the project is Dr. Bruce Vogel, whose contact information is as follows:

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See Dr. Vogel's Curriculum Vitae (CV) attached.

2) No Conflict of Interest.

The state has assured that the Independent Evaluator will conduct a fair and impartial evaluation, will prepare an objective Evaluation Report, and that there will be no conflict of interest. "Conflict of Interest" statements have been signed by appropriate Agency staff attesting to the following: No immediate family or business partners have financial interest in the vendor; no immediate family or business partners have a personal relationship with the vendor or their representatives; no gratuities, favors, or anything of monetary value has been offered to or accepted by the vendor or their representatives; no state parties have been employed by the vendor within the past 24 months; no discussions to seek or accept future employment with the vendor or their representatives; and, no other conditions exist which may cause conflict of interest.

3) Evaluation Budget.

The Agency initially contracted with UF for a period of three (3) years (SFY 2016-17 through SFY 2018-19) at a total cost of $1,290,600.00 ($430,200 per year). In the first three years, DYs 9, 10, and 11 will be evaluated.

The Agency is currently renewing the contract for a period of three years (SFY 2019-20 through SFY 2021-22) during which time DYs 12, 13, and 14 will be evaluated. The budget for SFY 2019-20 through SFY 2021-22 is $2,652,575.50.

Component 9 and 10 will be added to the Agency's contract with the university, at which time a revised budget will be requested from the evaluators.

4) Timeline and Major Milestones.

Table 72 outlines the timeline for conducting the evaluation activities, including deliverable submissions and activities related to the renewal and reprocurement of a contractor.

Timelines for Component 9 and 10 will be updated upon CMS approval.

Table 72. MMA Evaluation Activities, December 31, 2017-December 31, 2023

Deliverable / Activity	Due Date
Evaluation Design submitted to CMS*	January 31, 2018
MMA Interim Report - Project 2 DY10: Component 3 (Healthy Behaviors)	April 2, 2018
MMA Interim Report - Project 3 DY10: Component 4 (LIP)	April 2, 2018
MMA Interim Report - Project 1 DY10: Components 1, 2, 5, and 7 (Access, Quality, Cost)	May 1, 2018
Revised Evaluation Design submitted to CMS*	May 7, 2018
MMA Interim Report - Project 4 DY10: Component 6 (Dual-Eligibles)	May 15, 2018
DY11 MMA Program Medicaid Data Request and Verification	Request Due: July 2, 2018 Verification Due: 30 calendar days after data delivery
DY11 Florida Center Data Request and Verification	Request Due: July 2, 2018 Verification Due: 30 calendar days after data delivery
Stakeholder Debriefing Materials	September 4, 2018

Stakeholder Debriefing and Summary	Thirty (30) calendar days after Debriefing completion

Deliverable / Activity	Due Date
Annual Monitoring Report due to CMS*	September 30, 2018
MMA Interim Report-Project 1 DY11-Components 1, 2, 5, and 7 (Access, Quality, Cost)	May 1, 2019
MMA Interim Report-Project 2 DY11-Component 3 (Healthy Behaviors)	April 1, 2019
MMA Interim Report-Project 3 DY11-Component 4 (LIP)	March 1, 2019
MMA Interim Report-Project 4 DY11-Component 6 (Dual-Eligibles)	May 15, 2019
Agency contract with UF is renewed for three (3) years	July 1, 2019
DY12 MMA Program Medicaid Data Request and Verification	Request Due: July 2, 2019 Verification Due: 30 calendar days after data delivery
DY12 Florida Center Data Request and Verification	Request Due: July 2, 2019 Verification Due: 30 calendar days after data delivery
Annual Monitoring Report due to CMS*	September 30, 2019
MMA Interim Report-Project 1 DY12-Components 1, 2, 5, and 7 (Access, Quality, Cost)	March 1, 2020
MMA Interim Report- Project 2 DY12-Component 3 (Healthy Behaviors)	April 1, 2020

Deliverable / Activity	Due Date
MMA Interim Report- Project 3 DY12-Component 4 (LIP)	May 1, 2020
MMA Interim Report-Project 4 DY12-Component 6 (Dual-Eligibles)	May 15, 2020
DY13 MMA Program Medicaid Data Request and Verification	Request Due: July 2, 2020 Verification Due: 30 calendar days after data delivery
DY13 Florida Center Data Request and Verification	Request Due: July 2, 2020 Verification Due: 30 calendar days after data delivery
Annual Monitoring Report due to CMS*	September 30, 2020
DY14 MMA Program Medicaid Data Request and Verification	Request Due: October 1, 2020 Verification Due: 30 calendar days after data delivery
DY14 Florida Center Data Request and Verification	Request Due: October 1, 2020 Verification Due: 30 calendar days after data delivery
MMA Interim Report-Project 1 DYs 13 and 14- Components 1, 2, 5 (DY13 only), and 7 (Access, Quality, Cost)	March 1, 2021
MMA Interim Report- Project 2 DYs 13 and 14-Component 3 (Healthy Behaviors)	April 1, 2021
MMA Interim Report- Project 3 DYs 13 and 14-Component 4 (LIP)	May 1, 2021

Deliverable / Activity	Due Date
MMA Interim Report-Project 4 DYs 13 and 14-Component 6 (Dual-Eligibles)	May 15, 2021
Draft of Interim Evaluation Report DY14-Component 8 (Pre-paid Dental Health Program)	June 15, 2021
Draft of Draft Interim Evaluation Report (DYs 9-14) due to Agency	August 15, 2021
Annual Monitoring Report due to CMS*	September 30, 2021
DY15 MMA Program Medicaid Data Request and Verification	Request Due: October 1, 2021 Verification Due: 30 calendar days after data delivery
DY15 Florida Center Data Request and Verification	Request Due: October 1, 2021 Verification Due: 30 calendar days after data delivery
Final Draft Interim Evaluation Report (DYs 9-14) due to Agency	November 1, 2021
Draft Interim Evaluation Report (DYs 9-14) due to CMS*	January 1, 2022
MMA Interim Report-Project 1 DY15-Components 1, 2, and 7 (Access, Quality, Cost)	March 1, 2022
MMA Interim Report- Project 2 DY15-Component 3 (Healthy Behaviors)	April 1, 2022
MMA Interim Report- Project 3 DY15-Component 4 (LIP)	May 1, 2022

MMA Interim Report-Project 4 DY15-Component 6 (Dual-Eligibles)	May 15, 2022

Deliverable / Activity	Due Date
Draft of Interim Evaluation Report DY15-Component 8 (Pre-paid Dental Health Program)	June 14, 2022
Anticipated Date of Execution of New Contract with UF	July 1, 2022
Annual Monitoring Report due to CMS*	September 30, 2022
DY16 MMA Program Medicaid Data Request and Verification	Request Due: October 1, 2022 Verification Due: 30 calendar days after data delivery
DY16 Florida Center Data Request and Verification	Request Due: October 1, 2022 Verification Due: 30 calendar days after data delivery
MMA Interim Report-Project 1 DY16-Components 1, 2, and 7 (Access, Quality, Cost)	March 1, 2023
MMA Interim Report- Project 2 DY16-Component 3 (Healthy Behaviors)	April 1, 2023
MMA Interim Report- Project 3 DY16-Component 4 (LIP)	May 1, 2023
MMA Interim Report-Project 4 DY16-Component 6 (Dual-Eligibles)	May 15, 2023

Draft of Draft Summative Evaluation Report (DYs 12-16) due to Agency	August 15, 2023
Annual Monitoring Report due to CMS*	September 30, 2023

Deliverable / Activity	Due Date
Final Draft Summative Evaluation Report (DYs 12-16) due to Agency	November 1, 2023
Draft Summative Evaluation Report (DYs 12-16) due to CMS*	December 31, 2023

*Deliverables due to CMS.

State of Florida
Ron DeSantis, Governor

Agency for Health Care Administration
Mary C. Mayhew, Secretary
2727 Mahan Drive Tallahassee, FL 32308

Mission Statement
Better Healthcare for All Floridians.