SFY 2022–2023

External Quality Review Technical Report

April 2024

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Glossary of Acronyms

42 CFR	Title 42 of the Code of Federal Regulations
AAAHC	Accreditation Association for Ambulatory Health Care
ADHD	Attention-Deficit/Hyperactivity Disorder
ADT	Admission, Discharge, Transfer
Agency	Florida Agency for Health Care Administration
AOD	Alcohol or Other Drug
BH	Behavioral Health
BMI	Body Mass Index
C-section	Caesarean Section
CAP	Corrective Action Plan
CCM	Chronic Care Management
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CHW	Case Health Worker
CM	Care Management
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CQS	Comprehensive Quality Strategy
CSR	Customer Service Representative
CY	Calendar Year(Jan–Dec)
DOH	Department of Health
DY	Demonstration Year
ED	Emergency Department
EDV	Encounter Data Validation
ENS	Encounter Notification Service
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
FAR	Final Audit Report
FFS	Fee-for-Service
FFY	Federal Fiscal Year(Oct–Sept)
FMEA	Failure Modes and Effects Analysis
HbA1c	Hemoglobin A1c
HCBS	Home and Community-Based Services

HEDIS®,[1] .... Healthcare Effectiveness Data and Information Set
HHS .... United States Department of Health and Human Services
HIE .... Health Information Exchange
HIPAA .... Health Insurance Portability and Accountability Act
HIV/AIDS .... Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPV .... Human Papillomavirus
HRA .... Health Risk Assessment
HSAG .... Health Services Advisory Group, Inc.
IC .... Inpatient Coordinator
ICD-10 .... International Classification of Diseases, 10th Revision
ICN .... Interchange Control Number
IRR .... Interrater Reliability
IS .... Information Systems
ITN .... Invitation to Negotiate
IVR .... Interactive Voice Response
LO .... Licensed Organization
LTC .... Long-Term Care
LTSS .... Long-Term Services and Supports
MCO .... Managed Care Organization
MCP .... Managed Care Plan
MLTSS .... Managed Long-Term Services and Supports
MLU .... Member Location Unit
MMA .... Managed Medical Assistance
MRRV .... Medical Record Review Validation
MSR .... Member Service Representative
MTM .... Medication Therapy Management
MY .... Measurement Year(Jan–Dec)
NA .... Not Applicable
NAS .... Neonatal Abstinence Syndrome
NCQA .... National Committee for Quality Assurance
NPI .... National Provider Identifier
NR .... Not Reported
OB/GYN .... Obstetrician/Gynecologist
P4P .... Pay for Performance

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

PAHP .... Prepaid Ambulatory Health Plan
PCCM .... Primary Care Case Management
PCP .... Primary Care Practitioner/Provider
PDENT-CH .... Percentage of Eligibles Who Received Preventive Dental Services
PDSA .... Plan-Do-Study-Act
PHE .... Public Health Emergency
PIHP .... Prepaid Inpatient Health Plan
PIP .... Performance Improvement Project
PMV .... Performance Measure Validation
PNM .... Provider Network Management
POC .... Plan of Care
PPA .... Potentially Preventable Admission
PPE .... Potentially Preventable Event
PPR .... Potentially Preventable Readmission
PPV .... Potentially Preventable ED Visit
PR .... Provider Relations
QAPI .... Quality Assessment/Assurance and Performance Improvement
QI .... Quality Improvement
RN .... Registered Nurse
SBIRT .... Screening, Brief Intervention and Referral for Treatment Regarding Substance Use Disorders
SDOH .... Social Determinants of Health
SFY .... State Fiscal Year(July–June)
SMI .... Serious Mental Illness
SMMC .... Statewide Medicaid Managed Care
SUD .... Substance Use Disorder
Tdap .... Tetanus, Diphtheria, and Pertussis
TOC .... Transition of Care
TPID .... Trading Partner Identifier
UM .... Utilization Management
VBC .... Value-Based Care
VBP .... Value-Based Purchasing

Executive Summary

Introduction to the Annual Technical Report

Overview and Purpose Statement

Title 42 of the Code of Federal Regulations (42 CFR) §438.364 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. Health Services Advisory Group, Inc. (HSAG), used the United States Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services' (CMS') December 2018 update of its External Quality Review (EQR) Toolkit for States when preparing this report.[1-1] To meet this requirement, the Florida Agency for Health Care Administration (Agency) contracted with HSAG as its EQRO to perform the assessment and produce this report for EQR activities conducted.

The purpose of this state fiscal year (SFY) 2022–2023 External Quality Review Technical Report (SFY 2022–2023 Technical Report) is to draw conclusions about the quality, timeliness, and access to healthcare services provided by the contracted plans.

[1-1] Centers for Medicare & Medicaid Services. CMS-R-305, External Quality Review (EQR) of Medicaid Managed Care, EQR Protocols, and Supporting Regulations. Available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html. Accessed on: Feb 5, 2024.

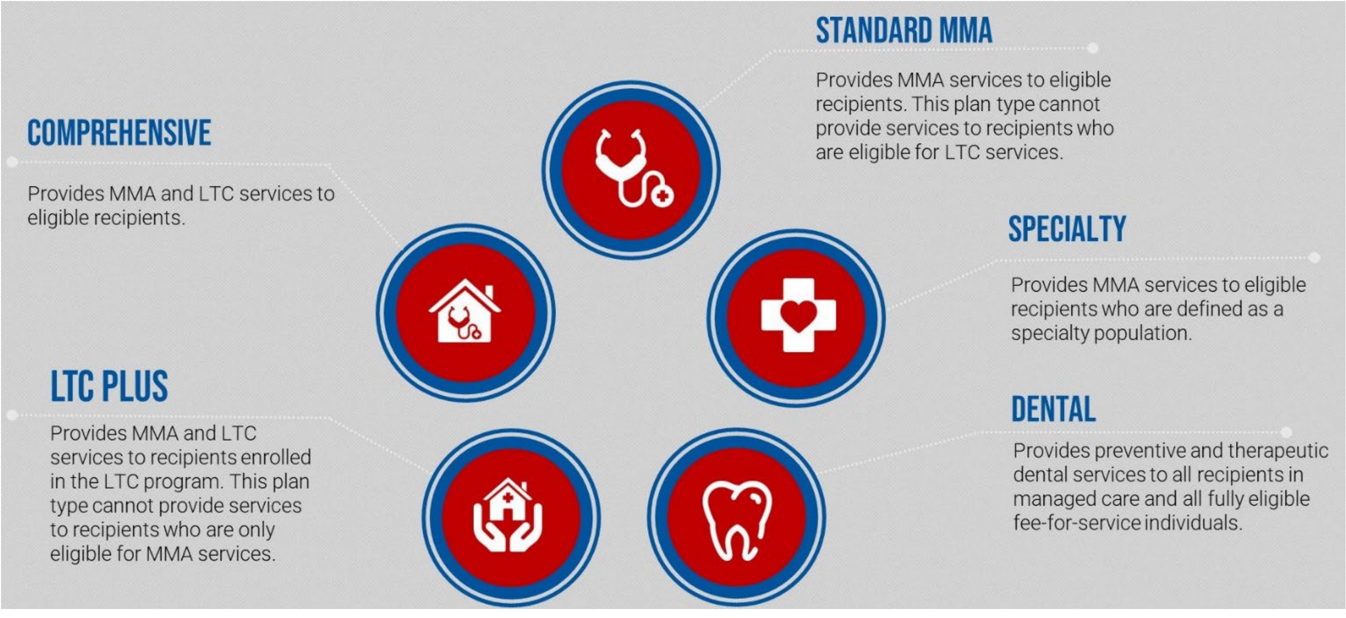
Overview of Florida's Managed Care Program

Statewide Medicaid Managed Care Program

In 2011, the Florida Legislature created the Statewide Medicaid Managed Care (SMMC) program, which has two components: the Managed Medical Assistance (MMA) program and the Long-Term Care (LTC) program. Under the SMMC program, most Medicaid beneficiaries receive their healthcare services through a managed care plan (MCP).

The Agency initiated a competitive re-procurement (Invitation to Negotiate [ITN]) of the SMMC contracts on July 14, 2017 (contract term through December 2024). The Agency awarded contracts to plans in each of the 11 regions of the state. Implementation of the SMMC contracts occurred over a three-phased schedule: Phase 1—December 1, 2018; Phase 2—January 1, 2019; and Phase 3—February 1, 2019. Under the new contracts, there are five plan types that may provide services, as shown in Figure 1-1.

Figure 1-1—Florida Plan Types



The Florida Legislature directed the Agency to implement a separate dental managed care component of the SMMC program. On October 16, 2017, the Agency 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, which also have five-year contracts (contract term through December 2024). The Agency selected three dental plans to operate statewide, with each dental plan operating in all 11 regions of the state.

The Agency also has a statewide specialty plan contract with the Department of Health (DOH) to serve children with chronic conditions through the Children's Medical Services-S. This contract is statutorily

exempt from the SMMC procurement requirements and requires the Children's Medical Services-S to meet all other requirements for the MMA Program.

Please see Appendix A for a list of the plans.

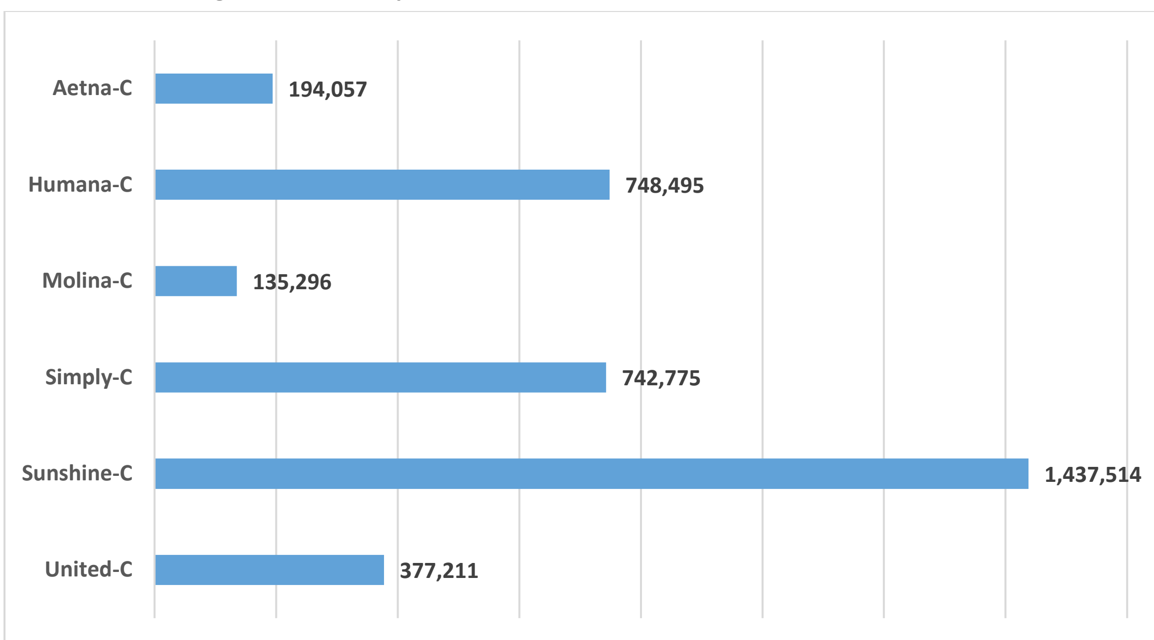
Florida Medicaid Managed Care Demographics

The demographics of the Florida Medicaid population (excluding the fee-for-service [FFS] population) as of June 30, 2023, were as follows.[1-2]

- Approximately 3.8 million were enrolled in a comprehensive or standard MMA plan.
- Approximately 340,000 were enrolled in a specialty plan.
- Approximately 130,000 were enrolled in the LTC program.
- Approximately 4.5 million were enrolled in a dental plan.

Figure 1-2 through Figure 1-6 show plan Medicaid enrollment as of June 30, 2023.

Figure 1-2—Comprehensive Plan Enrollment as of June 30, 2023



[1-2] Agency for Health Care Administration. Florida Statewide Medicaid Monthly Enrollment Report. Available at: https://ahca.myflorida.com/medicaid/finance/data_analytics/enrollment_report/index.shtml. Accessed on: Feb 5, 2024.

Figure 1-3—MMA Plan Enrollment as of June 30, 2023

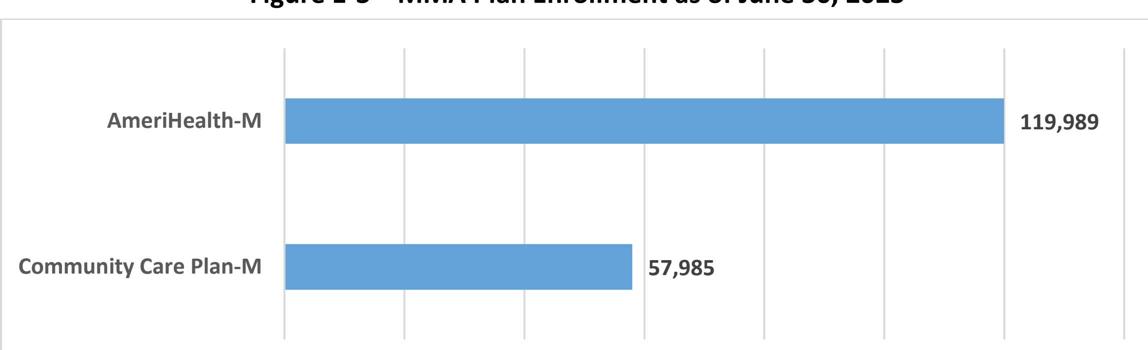


Figure 1-4—Specialty Plan Enrollment as of June 30, 2023

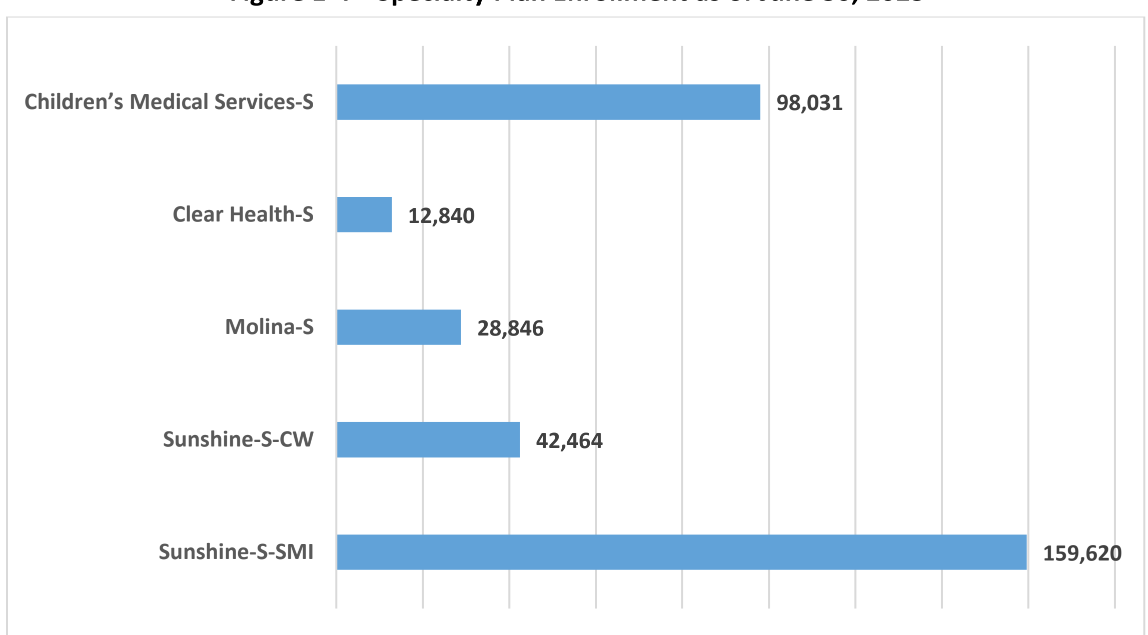


Figure 1-5—LTC Plan Enrollment as of June 30, 2023

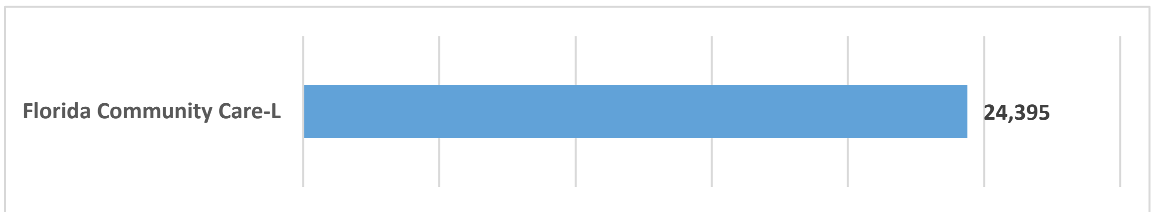
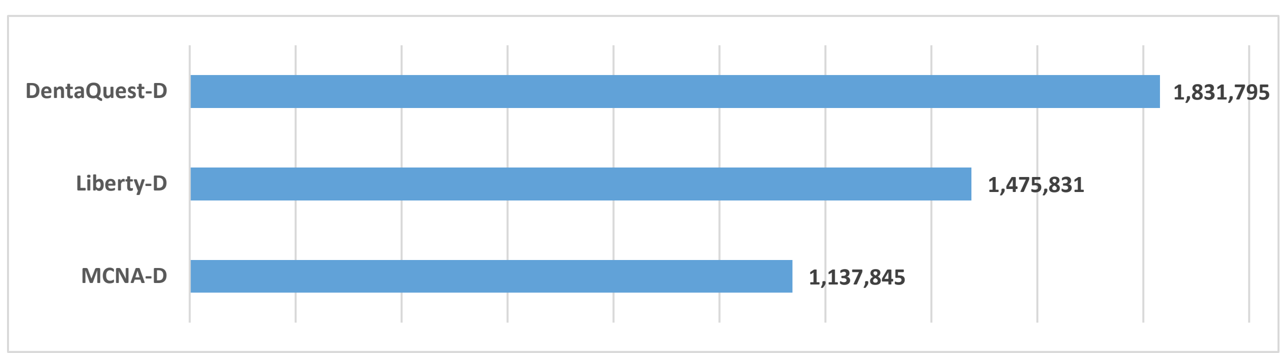


Figure 1-6—Dental Plan Enrollment as of June 30, 2023



Quality Strategy

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 enrollees and update it every three years. The Comprehensive Quality Strategy (CQS) outlines Florida's strategy for assessing and improving the quality of healthcare and services furnished by the plans and other providers within the Florida Medicaid system.[1-3] The Agency began the process of updating the CQS during demonstration year (DY) 13 and completed this process during DY 14 (July 1, 2019, through June 30, 2020). The CQS addresses various strategies to assess progress toward 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 (QI) is a continual process. In line with the Agency's goals outlined in its quality strategy, the Agency identified three priorities for Florida Medicaid. 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.

[1-3] Agency for Health Care Administration. Comprehensive Quality Strategy. Available at: https://ahca.myflorida.com/medicaid/policy_and_quality/quality/docs/Comprehensive_Quality_Strategy_Report.pdf. Accessed on: Feb 5, 2024.

Table 1-1—Three Priorities and Corresponding Goals[1-4]

Priority 1:	Priority 2:	Priority 3:
Improve the recipient's experience of care	Improve the overall health of the Medicaid population	Continue to bend the Medicaid cost curve

Goal: Reduce Potentially Preventable Events (PPEs)

- Admissions
- Readmissions
- Emergency department (ED) visits

Goal: Improve Birth Outcomes

- Reduce primary Caesarean section (C-section) rate
- Reduce pre-term birth rate
- Reduce the rate of Neonatal Abstinence Syndrome (NAS)

Goal: Improve Access to Dental Care

- Increase the percentage of children receiving preventive dental services
- Reduce potentially preventable dental-related ED visits

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

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by CMS (CMS EQR protocols).[1-5] The purpose of these activities, in general, is to improve states' ability to oversee and manage plans they contract with for services, and help plans improve their performance with respect to quality, timeliness, and access to care. Effective implementation of the EQR-related activities will facilitate state efforts to purchase high-value care and to achieve higher-performing healthcare delivery systems for Medicaid and Children's Health Insurance Program (CHIP) members. For the SFY 2022–2023 Technical Report assessment, HSAG used

[1-4] Ibid

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: http://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 23, 2024.

findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality, timeliness, and access to care and services provided by each plan.

Table 1-2—EQR Activities

Activity	Description	CMS EQR Protocol
Mandatory Activities		
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a plan used sound methodology in its design, implementation, analysis, and reporting.	**Protocol 1.** Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by a plan are accurate based on the measure specifications and state reporting requirements.	**Protocol 2.** Validation of Performance Measures
Compliance with Standards*	This activity determines the extent to which a Medicaid and CHIP plan is in compliance with federal standards and associated state-specific requirements, when applicable.	**Protocol 3.** Review of Compliance with Medicaid and CHIP Managed Care Regulations
Optional Activities		
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by a plan.	**Protocol 5.** Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan

* HSAG received the documentation for compliance monitoring for this activity from the Agency.

Aggregating and Analyzing Statewide Data

For each comprehensive, standard, and specialty plan, HSAG analyzed the results obtained from each EQR activity. HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and access to care furnished by each plan, as well as the program overall. To produce Florida's SFY 2022–2023 Technical Report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and access to care and services provided by the plans.

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each plan to identify strengths and weaknesses in each domain of quality, timeliness, and access to services furnished by the plan for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and access to care and services furnished by the plans.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of, quality, timeliness, and access to care and services furnished by the plans.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and access to care for the program.

Detailed information about each activity's methodology is provided in Appendix B of this report. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each plan, please refer to the results of each activity in sections 2 through 4 of this report, as well as in Appendix C for a plan-specific analysis.

Quality, Timeliness, and Access

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

Quality
as it pertains to EQR, means the degree to which an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (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.[1]

Timeliness
as it pertains to EQR, is described by the National Committee for Quality Assurance (NCQA) to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] 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).

Access
as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by MCPs 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.[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. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

How Conclusions Were Drawn From EQRO Activities

To draw conclusions about the quality, timeliness, and access to care provided by the plans, HSAG assigned each of the EQR activities to one or more of three domains. Assignment to these domains is depicted in Table 1-3.

Table 1-3—EQR and Agency Activities and Domains

Activity	Quality	Timeliness	Access
Validation of PIPs	✓	✓	✓
Validation of Performance Measures	✓	✓	✓
Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™,[1-6]	✓		✓
Review of Compliance with Medicaid and CHIP Managed Care Regulations	✓	✓	✓
Encounter Data Validation	✓	✓	✓

Florida Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from SFY 2022–2023 to comprehensively assess the plans' performance in providing quality, timely, accessible healthcare services to Agency Medicaid and CHIP members. For each plan reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the plans' performance, which can be found in sections 2 through 4 and Appendix C of this report. The overall findings and conclusions for all plans were also compared and analyzed to develop overarching conclusions and recommendations for the Florida managed care program. Table 1-4 highlights substantive findings and actionable state-specific recommendations, when applicable, for the Agency to further promote its CQS goals and objectives.

Table 1-4—Florida Managed Care Program Substantive Findings

Program Strengths	
+	**Quality, Timeliness, and Access** • **Overall:** The PIPs were methodologically sound, most data reported in the PIPs appeared to be accurate, and the implemented targeted interventions were linked to the identified barriers and actively engaged the enrollees or providers to improve access to, quality of, and timeliness of care. **MMA Program**: The statewide average for the *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication* measure met or exceeded the Agency's MY 2022 performance target (performance target).

[1-6] HEDIS Compliance Audit™ is a trademark of the NCQA.

	Program Strengths
⊕	• **Dental Plans**: The statewide rates for both measure indicators of Sealant Receipt on Permanent First Molars demonstrated an increase of more than 9 percentage points from the prior MY. • **Dental Plans**: For the Preventive Dental Services for Children PIP, two out of three dental plans achieved statistically significant improvement over the baseline, and all dental plans reported achievement of significant clinical improvement. • **Dental Program:** Statewide rates for both measure indicators of Follow-Up After Emergency Department Visits for Dental Caries in Children improved by more than 3 percentage points in MY 2022 relative to MY 2021.
⊕	**Quality** • **Overall**: The Agency-conducted compliance review results for the plans were high. The Agency's compliance review scores for all plans were 100 percent. • **MMA Program**: Ten of the 13 plans met or exceeded the performance target for the *Chlamydia Screening in Women—Total* measure. • **MMA Program**: Eight of the 13 plans met or exceeded the performance target for the *Asthma Medication Ratio* measure.
⊕	**Quality and Timeliness** • **LTC Program:** The statewide average for the *Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update* measure and the *LTSS Comprehensive Care Plan and Update* measure met or exceeded the performance targets. • **LTC Program:** Analysis of plan of care (POC) documentation for the EDV study indicated an overall high procurement rate and high validity rate of the submitted documentation. The quality of the POC documentation was generally high, with proper signatures, effective dates aligning with selected dates of service, and identification of valid servicing providers.
⊕	**Quality and Access** • **MMA Program**: The statewide average for the *Childhood Immunization Status—Combination 3* and *Childhood Immunization Status—Combination 7* measure indicators met or exceeded the performance targets.
⊕	**Timeliness and Access** • **MMA Program:** For the Administration of the Transportation Benefit PIP, six out of 10 plans reported a CY 2021 rate at or above the goal of 90 percent. • **Dental Program:** For the Coordination of Transportation Services PIP, only one dental plan achieved statistically significant improvement over the baseline rate.

Program Weaknesses	
⊖	**Quality, Timeliness, and Access** • **MMA Program:** Of the 13 plans reporting the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP, only three health plans reported achievement of statistically significant improvement over the baseline during CY 2021; however, the improvement of the three health plans was achieved in only one of the three performance indicators. • **MMA Program:** For both PIPs, opportunities for improvement were noted in the documentation of the statistical testing results to eliminate errors in the statistical testing results comparing remeasurement data to the baseline. • **MMA Program:** The statewide average rate for *the Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator declined from MY 2021 by 1.43 percentage points; and for a second year in a row, statewide average rates fell below the minimum performance target. • **Dental Program:** From MY 2021 to MY 2022, the statewide rate for the *Topical Fluoride for Children—Dental or Oral Health Services—Total (1–20 Years)* measure indicator demonstrated a decline of more than 11 percentage points, and the statewide rate for the *Follow-Up After Dental-Related Emergency Department Visits—Total* measure indicator demonstrated a decline of more than 5 percentage points.
⊖	**Quality** • **LTC Program:** The *LTSS Shared Care Plan with PCP—Shared Care Plan with PCP* measure rate declined by 3.86 percentage points. • **LTC Program:** Some plans' LTC record submissions for the EDV study were low which affected the LTC record omission study indicators for all key data elements evaluated. • **LTC Program:** Some plans' LTC record submissions for the EDV study did not include complete and accurate supporting documentation. • **Dental Program:** All dental plans fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator.
⊖	**Quality and Timeliness** • **MMA Program:** The statewide average for *Lead Screening in Children* demonstrated a decline of more than 3 percentage points from MY 2021 to MY 2022.
⊖	**Access** • **MMA Program:** The statewide average measure rate fell below the minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure for the second year in a row.
⊖	**Timeliness and Access** • **MMA Program:** Nine of the 13 plans with a reportable measure rate fell below the minimum performance target for the *Childhood Immunization Status—Combination 10* measure.

Recommendations for Targeting Goals and Objectives in the State's Quality Strategy

HSAG's EQR results and guidance on actions assist the Agency in evaluating the plans' performance and progress in achieving the goals of the program's quality strategy. These actions, if implemented, may assist the Agency and the plans in achieving and exceeding goals. In addition to providing each plan with specific guidance, HSAG offers the Agency the following recommendations, which should positively impact the quality, accessibility, and timeliness of services provided to Medicaid members.

Domain	Program Recommendations	Quality Strategy Priority & Goal
Quality, Timeliness, and Access	For the PIPs with unsuccessful outcomes, HSAG recommends that the plans revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that the plans ensure that data-driven decisions are made to revise the interventions to realize improvement. HSAG also recommends that the plans consider seeking enrollee input to better understand enrollee-related barriers toward access to care.	**Priority:** • Improve the overall health of the Medicaid population. **Goal:** • Reduce potentially preventable events (PPEs).
Quality, Timeliness, and Access	HSAG recommends that the plans serving the MMA program consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care, when designing strategies to improve performance rates. In addition, HSAG recommends that the plans consider whether there are disparities/social determinants of health (SDOH) within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plans implement appropriate interventions to reduce barriers to care.	**Priority:** • Improve the overall health of the Medicaid population. **Goal:** • Improve birth outcomes.
Quality, Timeliness, and Access	To improve follow-up after members access the ED or are hospitalized for mental illness, HSAG recommends that the plans conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that the plans enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with behavioral health (BH) needs. In addition, HSAG recommends that the plans partner with their contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. **Goals:** • Reduce PPEs. • Continue to bend the Medicaid cost curve.

Domain	Program Recommendations	Quality Strategy Priority & Goal
Quality, Timeliness, and Access	HSAG recommends that the plans conduct an SDOH analysis to identify any disparities preventing members from receiving dental treatment services. Upon identification of any health disparities in the plans' populations, HSAG recommends that the plans implement appropriate interventions to improve access to care. If barriers to care are impacting the rates, HSAG recommends that the plans also evaluate their networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends that the plans work with providers to offer extended office hours/weekend availability, telehealth appointments, or mobile clinics for members who may have barriers such as work or transportation.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. **Goal:** • Improve access to dental care.
Quality	HSAG recommends that the Agency incorporate chart/case file review of plan denials, grievances, and appeals as part of the compliance review. A case file review will determine the plan's compliance with meeting federal and State requirements in addition to timeliness and accuracy of reporting.	**Priority:** • Improve the recipient's experience of care.
Quality	HSAG recommends that the plans evaluate opportunities to enhance care coordination with PCPs. HSAG recommends that plans partner with their contracted providers to identify and resolve any barriers that impede the ability to share care plans with PCPs and coordinate patient monitoring following the recommended guidelines.	**Priorities:** • Improve the recipient's experience of care. • Improve the overall health of the Medicaid population. **Goal:** • Increase the percentage of enrollees receiving long-term care services in their own home or the community instead of a nursing facility.
Quality	To ensure the plans' accountability for encounter data record procurement requirements, HSAG recommends that the Agency consider strengthening and/or enforcing its contract requirements and oversight (see Section 5 for more details).	**Priority** • Continue to bend the Medicaid cost curve.
Quality	HSAG recommends that the Agency consider establishing clear standards for encounter data record submission to ensure plans are more responsive in procuring requested records. HSAG also recommends that the Agency monitor compliance with record submission standards and take appropriate action for noncompliant plans.	**Priority** • Continue to bend the Medicaid cost curve.

Domain	Program Recommendations	Quality Strategy Priority & Goal
Access	HSAG recommends that the plans conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plans implement appropriate interventions to improve performance. HSAG recommends that the plans work with members to increase the use of telehealth services, when appropriate.	**Priority:** • Improve the recipient's experience of care.
Quality and Timeliness	HSAG recommends that the plans conduct a segmentation analysis of noncompliant members in the measure to determine why some children did not receive blood lead tests by their second birthday. Upon identification of any root causes contributing to this gap in care, HSAG recommends that the plans implement appropriate interventions to improve the use of evidence-based practices related specifically to this pediatric screening. Additionally, HSAG recommends that plans confirm that providers are trained to document the applicable screening test codes needed to meet compliance. Documentation of the correct codes or verbiage in the medical record is important to meet numerator compliance.	**Priority:** • Improve the overall health of the Medicaid population. **Goals:** • Reduce PPEs. • Continue to bend the Medicaid cost curve.
Quality and Access	HSAG recommends that the plans identify best practices for ensuring children receive medically appropriate preventive influenza vaccinations. HSAG recommends that plans consider whether there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, HSAG recommends that plans implement appropriate interventions to improve the immunization rates. Additionally, for all childhood immunizations, HSAG recommends that plans break down the data by immunization to identify specific immunizations(s) that were administered less frequently to assist in determining better efforts to administer the specific immunization(s).	**Priority:** • Improve the overall health of the Medicaid population. **Goals:** • Reduce PPEs. • Continue to bend the Medicaid cost curve.

Overview of External Quality Review Activities Related to Quality, Timeliness, and Access

Review of Compliance

The compliance review evaluates plan compliance with federal and state requirements and includes all required CMS standards and related Florida-specific plan contract requirements. The Agency conducts compliance review activities for each plan at least once during each three-year EQR cycle. In addition, the Agency conducts compliance monitoring activities for each plan at least once during each three-year EQR cycle. The compliance review and the compliance monitoring standards are derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period.

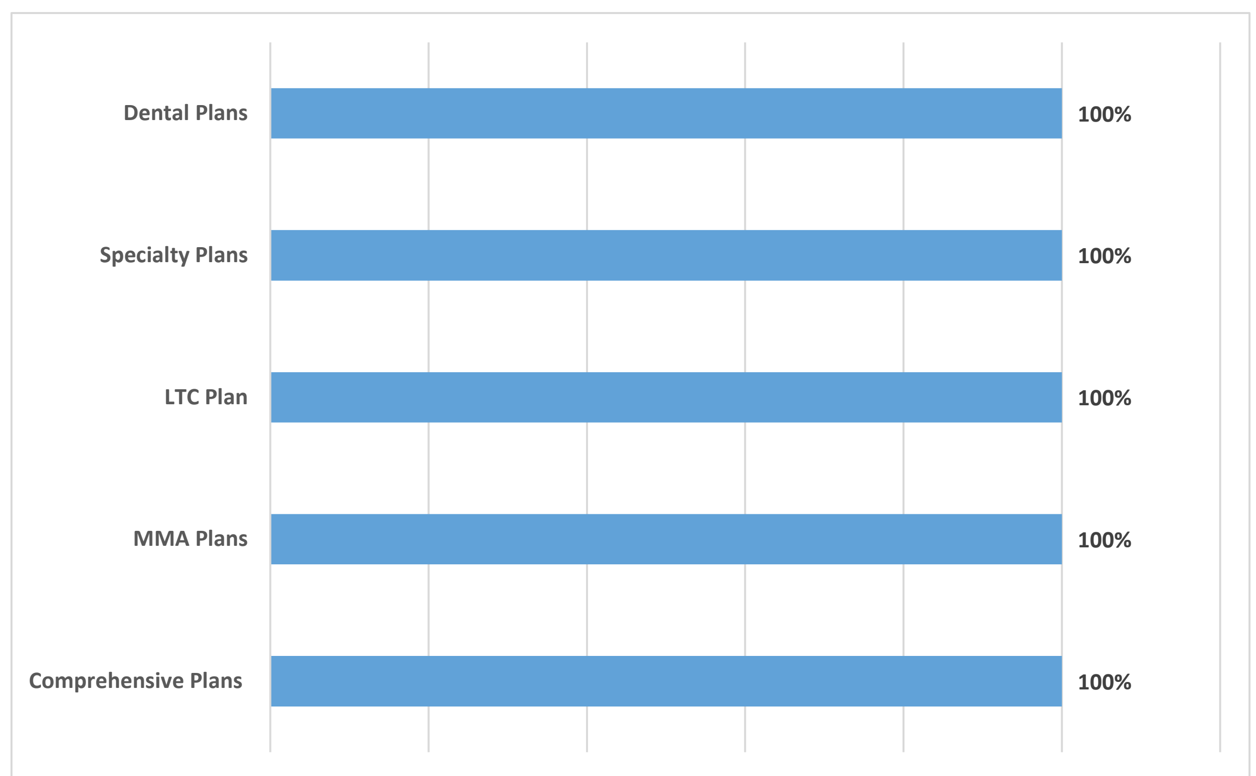
Beginning in CY 2022, the Agency conducted compliance reviews with all health plans. All federal standards were reviewed, thereby completing the requirements for a three-year compliance review cycle of January 1, 2022–December 2024. Table 1-5 displays the 14 standards that were reviewed.

Table 1-5—Compliance Review Standards

Standard #	Standard Name	CFR
I	Disenrollment Requirements and Limitations	438.56
II	Enrollee Rights and Confidentiality	438.100 438.224
III	Member Information	438.10
IV	Emergency and Poststabilization Services	438.114
V	Adequate Capacity and Availability of Services	438.206 438.207
VI	Coordination and Continuity of Care	438.208
VII	Coverage and Authorization of Services	438.210
VIII	Provider Selection	438.214
IX	Subcontractual Relationships and Delegation	438.230
X	Practice Guidelines	438.236
XI	Health Information Systems	438.242
XII	Quality Assessment and Performance Improvement	438.330
XIII	Grievance and Appeal Systems	438.228
XIV	Program Integrity	438.608 438.610

Figure 1-7 presents an overall summary of the plan compliance review results for all 14 standards reviewed during the 2022 compliance review for all plan types.

Figure 1-7—All Plan Types Overall Compliance Ratings for Three-Year Period: SFY 2022–2024



Performance Improvement Projects

As part of the Agency's procurement of the SMMC contracts for the MMA program, the Agency focused on three program goals:

- Reduce PPEs, including hospital admissions, hospital readmissions, and ED visits.
- Improve birth outcomes by reducing primary C-sections, pre-term birth rates, and rates of NAS.
- Improve care transitions by increasing the percentage of enrollees receiving LTC services in their own home or the community instead of a nursing facility.

In the procurement of the SMMC dental plan contracts, the Agency focused on the program goal of improving access to dental care by:

- Increasing the percentage of children receiving preventive dental services.
- Reducing potentially preventable dental-related ED visits.

Through the procurement process, the plans committed to meeting specific targets related to potentially preventable hospital events and birth outcomes, while the dental plans committed to meeting specific targets related to potentially preventable dental-related ED visits and preventive dental services for children. The Agency contractually required all plans to conduct PIPs in selected areas to align the plans in achieving the Agency's program goals and to focus the plans' efforts toward meeting the targets they set for each area.

The Agency also contractually required the plans serving the MMA program to focus on mental/behavioral health or the integration of mental healthcare with primary care as a plan-selected third PIP topic. In SFY 2020−2021, the Agency amended the requirement for a plan-selected third PIP topic to that of a mandated requirement of initiating a new Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. This amendment was initiated by the Agency after considering historical and calendar year (CY) 2019 HEDIS data for the targeted measures.

For the administrative/nonclinical PIP, the Agency contractually required all plans to focus on transportation and ensure that enrollees are transported to their medical and dental appointments on time as a means of improving access to care.

During SFY 2022–2023, the plans submitted four state-mandated PIPs to HSAG for either validation or a high-level review. SFY 2022–2023 was the fifth year for the validation and review of all PIPs except the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP, which was initiated in SFY 2020–2021.

Table 1-6 displays the PIP topics and the type of review conducted by HSAG for the plans.

Table 1-6—SFY 2022–2023 PIP Topics and Review Type for Plans

PIP Topic	Review Type
Administration of the Transportation Benefit	Validation
Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	Validation
Youth Transitions to Adult Care Reducing Asthma Related PPEs for Pediatric Enrollees (Plan-Selected, Children's Medical Services-S only)	Validation
Improving Birth Outcomes*,^	High-Level Review
Reducing PPEs*	High-Level Review

* These state-mandated PIP topics were not initiated by the Children's Medical Services-S because the PIP topics were not applicable to the population served by the plan. Children's Medical Services-S instead submitted two additional PIPs for validation.

^ This PIP topic was not submitted by Florida Community Care-L because the PIP topic is not applicable to the LTC Plus population served by the plan.

The dental plans submitted three state-mandated PIPs. Table 1-7 displays the PIP topics and the type of review conducted by HSAG for the dental plans. SFY 2022–2023 was the fifth year for the validation and review of all three topics.

Table 1-7—SFY 2020–2021 PIP Topics and Review Type for Dental Plans

PIP Topic	Review Type
Coordination of Transportation Services With the SMMC Plans	Validation
Preventive Dental Services for Children	Validation
Reducing Potentially Preventable Dental-Related Emergency Department Visits	High-Level Review

Performance Measure Validation

HSAG conducted PMV activities for the measures calculated and reported by the comprehensive plans, MMA plans, specialty plans, dental plans, and one LTC Plus plan for SFY 2022–2023. All plan measure indicator data were audited by an NCQA licensed organization (LO) in line with the NCQA HEDIS Compliance Audit 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, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 2).[1-7] This included validating the audit process to ensure key audit activities were performed and verifying that performance measure indicator rates were collected, reported, and calculated according to the specifications required by the state.

Comprehensive, MMA, and Specialty Plans

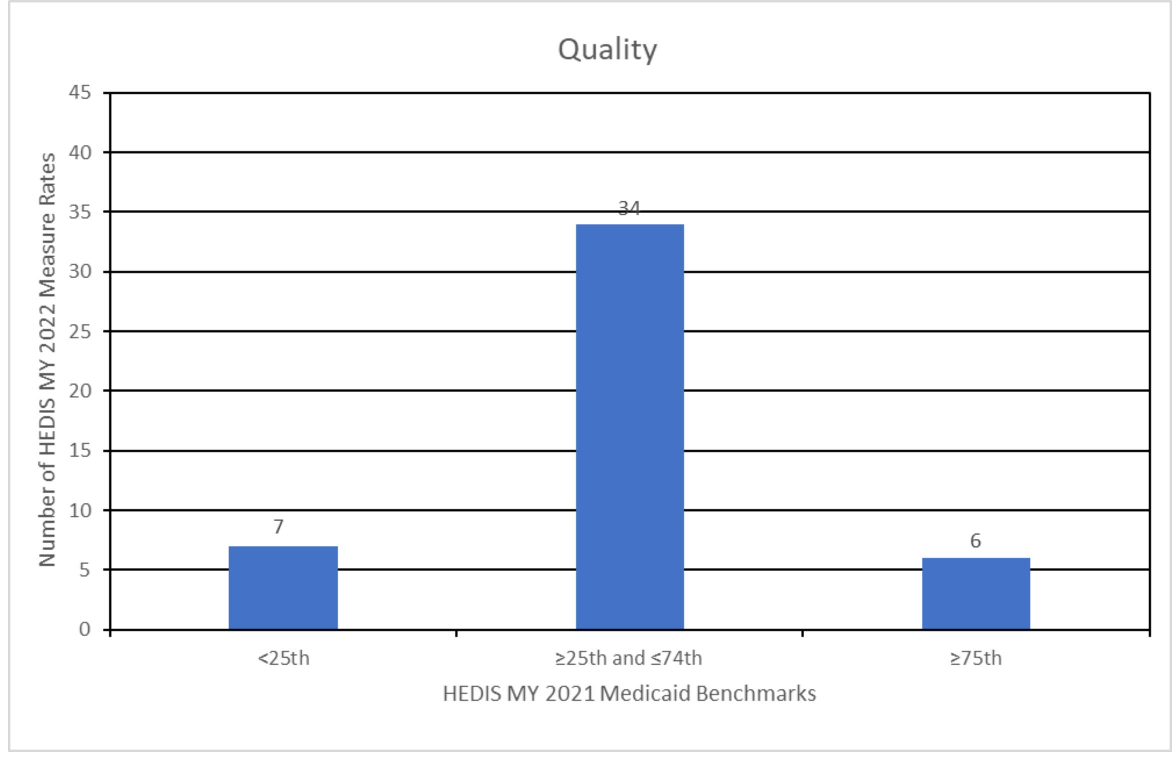
Plans were required to report 88 performance measure indicators. The Agency established performance targets for 49 of the measure indicators based on the HEDIS measurement year (MY) 2021 Quality Compass national Medicaid All Lines of Business 75th percentile. Minimum performance targets were also established based on the 25th percentile. The measure indicators were grouped into six domains (Pediatric Care, Women's Care, Living with Illness, Behavioral Health, Access/Availability of Care, and Appropriate Treatment and Utilization). In addition to the 88 measure indicators, comprehensive plans were required to report on 15 LTC measure indicators. Out of the 88 measure indicators, one measure indicator was to be reported by the specialty plans only. HSAG received final audit reports (FARs) that contained IS capability findings from all comprehensive, standard, and specialty plans. For the current MY, all plans were fully compliant with NCQA HEDIS Compliance Audit Information System (IS) standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.

As shown in Figure 1-8 below, 47 performance measure indicators comparable to benchmarks and related to quality were evaluated as part of the Pediatric Care, Women's Care, Living with Illness, Behavioral

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 23, 2024.

Health, and Access/Availability of Care domains. Of the 47 measure indicators related to quality, six (12.8 percent) met or exceeded the performance targets (the 75th percentile). The statewide average met or exceeded the minimum performance targets (the 25th percentile) for 40 of 47 (85.1 percent) measure indicators.

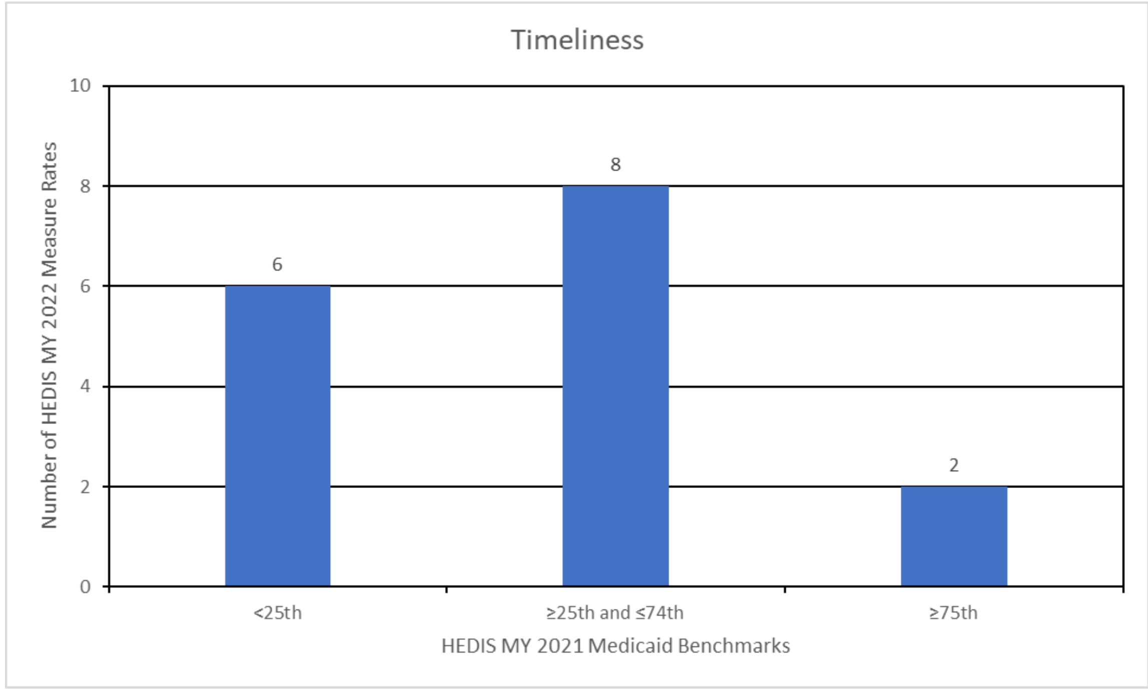
Figure 1-8—Performance Indicator Results Related to Quality



Note:
≥75th percentile is the performance target.
≥25th percentile is the minimum performance target.

As shown in Figure 1-9, 16 performance measure indicators comparable to benchmarks and related to **timeliness** were evaluated as part of the Pediatric Care, Women's Care, and Behavioral Health domains. Two of the 16 (12.5 percent) measure indicators in this area met or exceeded the performance targets (the 75th percentile). The statewide average met or exceeded the minimum performance targets (the 25th percentile) for 10 of 16 (62.5 percent) measure indicators.

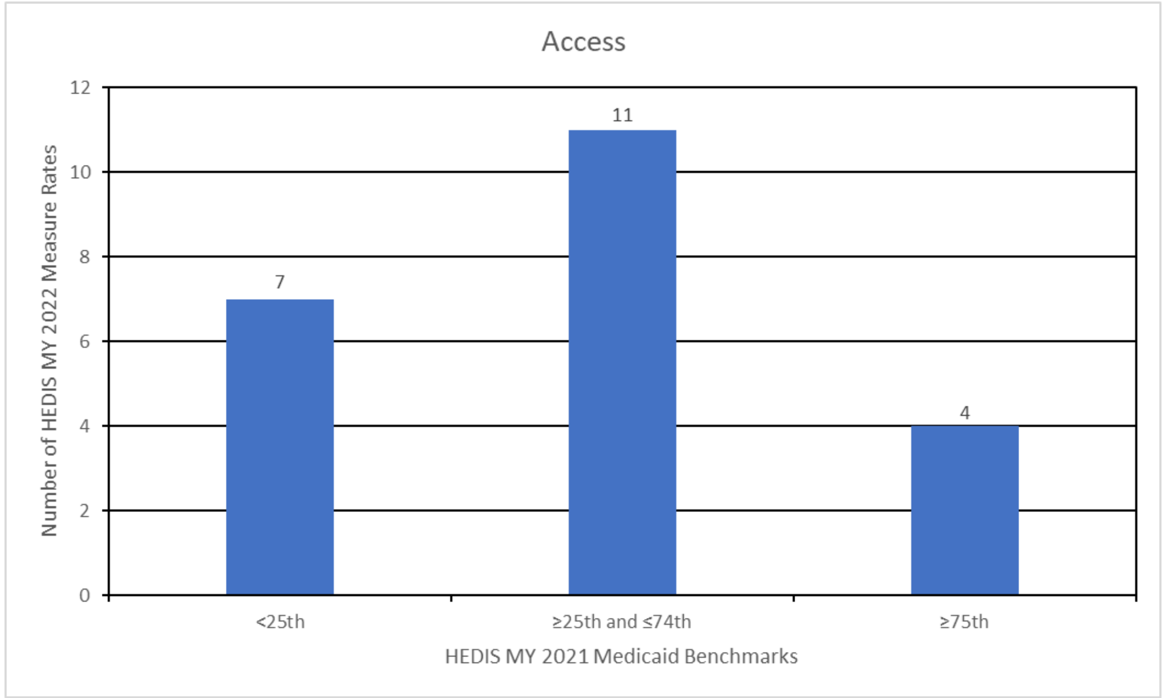
Figure 1-9—Performance Indicator Results Related to Timeliness



Note:
≥75th percentile is the performance target.
≥25th percentile is the minimum performance target.

As shown in Figure 1-10 below, 22 performance measure indicators comparable to benchmarks and related to **access** were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, Access/Availability of Care, and Appropriate Treatment and Utilization domains. Four of the 22 (18.2 percent) measure indicators in this area met or exceeded the performance targets (the 75th percentile). The statewide average met or exceeded the minimum performance targets (the 25th percentile) for 15 of 22 (68.2 percent) measure indicators.

Figure 1-10—Performance Indicator Results Related to Access



Note:
≥75th percentile is the performance target.
≥25th percentile is the minimum performance target.

Long-Term Care Program

For MY 2022, the six comprehensive plans and the one LTC Plus plan were required to report 15 Agency-required measure indicators. The Agency established performance targets for seven of those measure indicators. HSAG had no concerns with the data systems and processes used by the plans for LTC measure calculations based on the information presented in the FARs and/or final audit statements. The plans reporting LTC measures continued to have adequate validation processes in place to ensure data completeness and accuracy. Four of the seven (57.1 percent) measure indicators for which performance targets were established met or exceeded the performance targets for reported LTC Managed Long-Term Services and Supports (MLTSS)/HEDIS measures (85 percent for each measure indicator). HSAG received FARs that contained IS capability findings from all MMA and LTC plans. For the current MY, all plans were fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.

Dental Plans

For MY 2022, the dental plans were required to report 14 dental measure indicators. HSAG had no concerns with the data systems and processes used by the plans for dental measure calculations based on the information presented in the FARs and/or final audit statements. HSAG received FARs that contained IS capability findings from all three dental plans. For the current MY, all plans were fully compliant with the requirement that all three plans be audited by an LO.

Performance Snapshot

Table 1-8 shows the statewide average performance as compared to the Agency-identified performance targets and minimum performance targets, which were established based on NCQA's Quality Compass national Medicaid All Lines of Business 75th and 25th percentiles, respectively, for HEDIS MY 2021, and statewide rate increases or decreases from MY 2021 to MY 2022. Performance results for the comprehensive, standard, and specialty plans are grouped into the following domains of care:

- Pediatric Care
- Women's Care
- Living with Illness
- Behavioral Health
- Access/Availability of Care
- Appropriate Treatment and Utilization

Performance results for the LTC Plus plan and the dental plans are displayed in separate domains.

Table 1-8—Performance Snapshot SFY 2022–2023

Domain of Care	# of Rates	Met or exceeded the performance target (75th percentile)	Ranked below the minimum performance target (25th percentile)	Improved from prior year*	Declined from prior year**
Pediatric Care	14	▪ *Childhood Immunization Status—Combination 3* ▪ *Childhood Immunization Status—Combination 7* ▪ *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase* ▪ *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase*	▪ *Childhood Immunization Status—Combination 10*	▪ *None*	▪ *Lead Screening in Children* ▪ *Childhood Immunization Status—Combination 10*
Women's Care	5	▪ *None*	▪ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*	▪ *Prenatal and Postpartum Care—Postpartum Care*	▪ *None*
Living with Illness	10	▪ *Asthma Medication Ratio—Total*	▪ *None*	▪ *Blood Pressure Control for Patients With Diabetes* ▪ *Controlling High Blood Pressure* ▪ *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%)* ▪ *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)* ▪ *Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total (18+ Years)* ▪ *Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total (18+ Years)*	▪ *Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total (18+ Years)*

Domain of Care	# of Rates	Met or exceeded the performance target (75th percentile)	Ranked below the minimum performance target (25th percentile)	↑ Improved from prior year*	↓ Declined from prior year**
Behavioral Health	**16**		▪ *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* ▪ *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)* ▪ *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* ▪ *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)*	▪ *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* ▪ *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)*	▪ *None*
Access/ Availability of Care	**1**	▪ *None*	▪ *Adults' Access to Preventive/Ambulatory Health Services—Total*	▪ *None*	▪ *Adults' Access to Preventive/Ambulatory Health Services—Total*
Appropriate Treatment and Utilization	**2**	▪ *None*	▪ *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*	▪ *None*	▪ *None*
Long-Term Care^	**15**	▪ *LTSS Comprehensive Assessment and Update—Assessment of Core Elements* ▪ *LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements* ▪ *LTSS Comprehensive Care Plan and Update—Care Plan with Core Elements* ▪ *LTSS Comprehensive Care Plan and Update—Care Plan with Supplemental Elements*	▪ *None*	▪ *LTSS Comprehensive Assessment and Update—Assessment of Core Elements* ▪ *LTSS Reassessment/Care Plan Update After Inpatient Discharge —Reassessment and Care Plan Update After Inpatient Discharge*	▪ *LTSS Shared Care Plan with Primary Care Practitioner (PCP)—Shared Care Plan with PCP*

Domain of Care	# of Rates	Met or exceeded the performance target (75th percentile)	Ranked below the minimum performance target (25th percentile)	Improved from prior year*	Declined from prior year**
Dental Care#	14	▪ *None*	▪ *None*	▪ *Follow-Up After ED Visits for Dental Caries in Children —7-Day Follow-Up—Total (0-20 Years)* ▪ *Follow-Up After ED Visits for Dental Caries in Children —30-Day Follow-Up—Total (0-20 Years)* ▪ *Sealant Receipt on Permanent First Molars—At Least One Sealant* ▪ *Sealant Receipt on Permanent First Molars—All Four Permanent First Molars*	▪ *Topical Fluoride for Children—Dental or Oral Health Services—Total (1-20 Years)* ▪ *Follow-Up After Dental-Related ED Visits—Total*

* Statewide rate demonstrated an increase of more than 3 percentage points from MY 2021 to MY 2022.
** Statewide rate demonstrated a decline of more than 3 percentage points from MY 2021 to MY 2022.
# A plan-specific target was identified by the Agency for one dental measure, *Annual Dental Visit—Total*.
^ The Agency established performance targets for four reported LTC MLTSS/HEDIS measures (85 percent for each measure indicator).

Review of Compliance

Background

One mandatory EQR requirement is a review, conducted within the previous three-year period, to determine the health plan's compliance with the standards set forth in subpart D of 42 CFR §438.358 and the quality assessment and performance improvement (QAPI) requirements described in 42 CFR §438.330. In CY 2022, the first year of a new three-year review cycle (2022–2024), the Agency conducted a compliance review in accordance with §438.358. The Agency's compliance review assessed each plan's compliance with federal standards and the State contract requirements.

To conduct the compliance review, the Agency followed the guidelines set forth in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 3).[2-1] The Agency established a timeline and process to ensure that all federal standards are reviewed over the three-year compliance review cycle of January 1, 2022–December 31, 2024.

In accordance with CMS Protocol 3, the standards that are subject to this protocol include the following:

- §438.56 Disenrollment: Requirements and Limitations
- §438.100 Enrollee Rights
- §438.114 Emergency and Poststabilization Services
- §438.206 Availability of Services
- §438.207 Assurance of Adequate Capacity and Services
- §438.208 Coordination and Continuity of Care
- §438.210 Coverage and Authorization of Services

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 24, 2024.

- §438.214 Provider Selection
- §438.224 Confidentiality
- §438.228 Grievance and Appeal Systems
- §438.230 Subcontractual Relationships and Delegation
- §438.236 Practice Guidelines
- §438.242 Health Information Systems
- §438.330 QAPI Program

In collaboration with the Agency, in CY 2022, HSAG developed compliance review tools that included elements to assess the federal standards listed above as subject to CMS Protocol 3 and state contract requirements. Plan-specific tools were delivered to the Agency for use during its 2023 review process. The review standards included:

- Standard I—Disenrollment Requirements and Limitations
- Standard II—Enrollee Rights and Confidentiality
- Standard III—Member Information
- Standard IV—Emergency and Poststabilization Services
- Standard V—Adequate Capacity and Availability of Services
- Standard VI—Coordination and Continuity of Care
- Standard VII—Coverage and Authorization of Services
- Standard VIII—Provider Selection
- Standard IX—Subcontractual Relationships and Delegation
- Standard X—Practice Guidelines
- Standard XI—Health Information Systems
- Standard XII—QAPI Program
- Standard XIII—Grievance and Appeal Systems
- Standard XIV—Program Integrity

In July 2023, the Agency provided HSAG with a set of scored compliance review tools for each plan. A methodology for the compliance reviews and a sample of a compliance review tool can be found in Appendix B. The Agency assigned each element within the compliance review tools a score of *Met* or *Not Met*. The Agency exercised the deeming option to meet a portion of the EQR compliance review requirements; therefore, a number of elements were deemed, as described below. HSAG tallied the scores for each standard within the tool. HSAG used the information and data that the Agency provided from compliance reviews to reach conclusions and make recommendations about the quality, timeliness, and accessibility of care of Medicaid services provided to Medicaid enrollees.

Standards

Table 2-1 organizes the compliance review standards by plan functional area. Table 2-1 also specifies the related CMS categories of quality, timeliness, and access for each standard.

Table 2-1—Florida Compliance Reviews for All Plans

Standard #	Standard	CY 2023	Quality	Timeliness	Access
Provider Network Management					
V	Adequate Capacity and Availability of Services	✓	✓	✓	✓
VIII	Provider Selection	✓	✓	✓	✓
X	Practice Guidelines	✓	✓	✓	✓
Member Services and Experiences					
I	Enrollment and Disenrollment	✓		✓	✓
II	Member Rights and Confidentiality	✓		✓	✓
III	Member Information	✓	✓	✓	✓
VI	Coordination and Continuity of Care	✓	✓	✓	✓
Managed Care Operations					
IV	Emergency and Poststabilization Services	✓	✓	✓	✓
VII	Coverage and Authorization of Services	✓	✓	✓	✓
IX	Subcontractual Relationships and Delegation	✓	✓	✓	✓
XI	Health Information Systems	✓	✓	✓	✓
XII	QAPI Program	✓	✓	✓	✓
XIII	Grievance and Appeal System	✓	✓	✓	✓
XIV	Program Integrity	✓	✓	✓	✓

Deeming

The Agency requires the plans to be accredited by a national accrediting body, which allows the Agency to leverage or deem certain review findings from a private national accrediting organization that CMS has approved as applying standards at least as stringently as Medicaid under the procedures in 42 CFR §422.158 to meet a portion of the EQR compliance review requirements. The plans were accredited by NCQA, URAC (formerly known as the Utilization Review Accreditation Commission), or the Accreditation Association for Ambulatory Health Care (AAAHC). Table 2-2 includes the plans' private accreditation status, including the accrediting body and accreditation expiration date for each contracted plan.

Table 2-2—Plan Private Accreditation Status

Plan	Accrediting Body (Full Accreditation)	Other NCQA Accreditations, Certifications, and Distinctions	Expiration Date of Full Accreditation
AET-C	NCQA	• Electronic Clinical Data • Health Equity Accreditation	3/17/26
AMH-M	NCQA	• Electronic Clinical Data • Health Equity Accreditation • Multicultural Care	10/12/24
CMS-S	NCQA	• Health Equity Accreditation	3/10/26
CHA-S	NCQA	• Health Equity Accreditation • Health Equity Accreditation Plus • Long Term Services and Supports (LTSS) • Multicultural Care	6/17/25
CCP-M	NCQA	• Health Equity Accreditation • Multicultural Care	12/2/24 HE: 11/14/23
DQT-D	URAC	• Credentialing • Utilization Management	01/01/25
	NCQA		CR: 1/13/26 UM: 10/10/23
FCC-L	AAAHC	• None	12/11/25

Plan	Accrediting Body (Full Accreditation)	Other NCQA Accreditations, Certifications, and Distinctions	Expiration Date of Full Accreditation
HUM-C	NCQA	• Electronic Clinical Data • LTSS • Multicultural Care	12/7/25
LIB-D	URAC	• Credentialing • Utilization Management	7/1/25
	NCQA		11/12/24
MCA-D	URAC	• Credentialing	12/1/23
	NCQA		4/15/25
MOL-C	NCQA	• Health Equity • LTSS • Multicultural Care	1/6/26
MOL-S	NCQA – Interim Accreditation	• Health Equity Accreditation • LTSS • Multicultural Care	2/20/2024
SIM-C* SUN-C SUN-S-CW	NCQA	• Health Equity Accreditation • Health Equity Accreditation Plus • LTSS • Multicultural Care	4/1/25
SUN-S-SMI	NCQA	• LTSS • Health Equity Accreditation	11/5/24
UNI-C	NCQA	• Electronic Clinical Data • Health Equity Accreditation	1/20/25

**Note:* Vivida Health was acquired by Simply-C on 11/1/2022; therefore, the plan was not included in the compliance review process.

Federal regulations allow the Agency to exempt a plan from a review of certain administrative functions when the plan's Medicaid contract has been in effect for at least two consecutive years before the effective date of the exemption, and during those two years the plan has been subject to EQR and found to be performing acceptably for the quality of, timeliness of, and access to healthcare services it provides to Medicaid beneficiaries. The Agency has exercised the deeming option to meet a portion of the EQR compliance review requirements. The Agency followed the requirements in 42 CFR §438.362, which include obtaining:

- Information from a private national accrediting organization's review findings. Each year, the State must obtain from each plan the most recent private accreditation review findings reported on the plan, including:
  - All data, correspondence, and information pertaining to the plan's private accreditation review.
  - All reports, findings, and other results pertaining to the plan's most recent private accreditation review.
  - Accreditation review results of the evaluation of compliance with individual accreditation standards, noted deficiencies, CAPs, and summaries of unmet accreditation requirements.
  - All measures of the plan's performance.

The Agency deemed select review findings from the plans' private national accrediting organization survey. Table 2-3 indicates the number of elements for each plan identified as meeting the deeming requirements to meet a portion of the EQR compliance review requirements.

Table 2-3—2022 Deemed Compliance Review Elements

Standard #	Standard Name	Total Elements in Standard	Plans												
			AET-C	CMS-S	CCP-M	DQT-D	FCC-L	HUM-C	LIB-D	MCA-D	MOL-C	AMH-M	SIM-C	SUN-C	UNI-C
			Next Accreditation Survey (deeming review required)												
			3/23	2/25	12/24	1/25	9/24	12/22	7/22	12/23	1/23	10/24	4/25	11/24	1/25
			Number of Elements Deemed												
I	Enrollment and Disenrollment	8	0	0	0	0	0	0	0	0	0	0	0	0	0
II	Member Rights and Confidentiality	7	0	0	0	0	0	0	0	0	0	0	0	0	0
III	Member Information	21	15	15	15	11	7	15	11	15	15	15	15	15	15
IV	Emergency and Poststabilization Services	12	1	1	1	1	0	1	1	1	1	1	1	1	1
V	Adequate Capacity and Availability of Services	16	8	8	8	3	6	8	3	8	8	8	8	8	8
VI	Coordination and Continuity of Care	9	6	6	6	2	2	6	2	6	6	6	6	6	6
VII	Coverage and Authorization of Services	20	2	2	2	1	1	2	1	2	2	2	2	2	2

Standard #	Standard Name	Total Elements in Standard	AET-C	CMS-S	CCP-M	DQT-D	FCC-L	HUM-C	LIB-D	MCA-D	MOL-C	AMH-M	SIM-C	SUN-C	UNI-C
			Next Accreditation Survey (deeming review required)												
			3/23	2/25	12/24	1/25	9/24	12/22	7/22	12/23	1/23	10/24	4/25	11/24	1/25
			Number of Elements Deemed												
VIII	Provider Selection	10	2	2	2	2	1	2	2	2	2	2	2	2	2
IX	Subcontractual Relationships and Delegation	4	1	1	1	1	1	1	1	1	1	1	1	1	1
X	Practice Guidelines	3	3	3	3	0	3	3	0	3	3	3	3	3	3
XI	Health Information Systems	20	0	0	0	0	0	0	0	0	0	0	0	0	0
XII	Quality Assessment and Performance Improvement	8	4	4	4	2	3	4	2	4	4	4	4	4	4
XIII	Grievance and Appeal Systems	28	8	8	8	3	0	8	3	8	8	8	8	8	8
XIV	Program Integrity	14	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Score		**180**	**50**	**50**	**50**	**26**	**24**	**50**	**26**	**50**	**50**	**50**	**50**	**50**	**50**

The total number of elements per standard for the dental plans were less. The Agency removed elements determined to not be applicable to dental plans including those pertaining to advance directives, family planning, long-term services and supports, inpatient emergency services.
Note: Standard numbers and names align with the Agency's SFY 2022–2023 Compliance Review Tool.

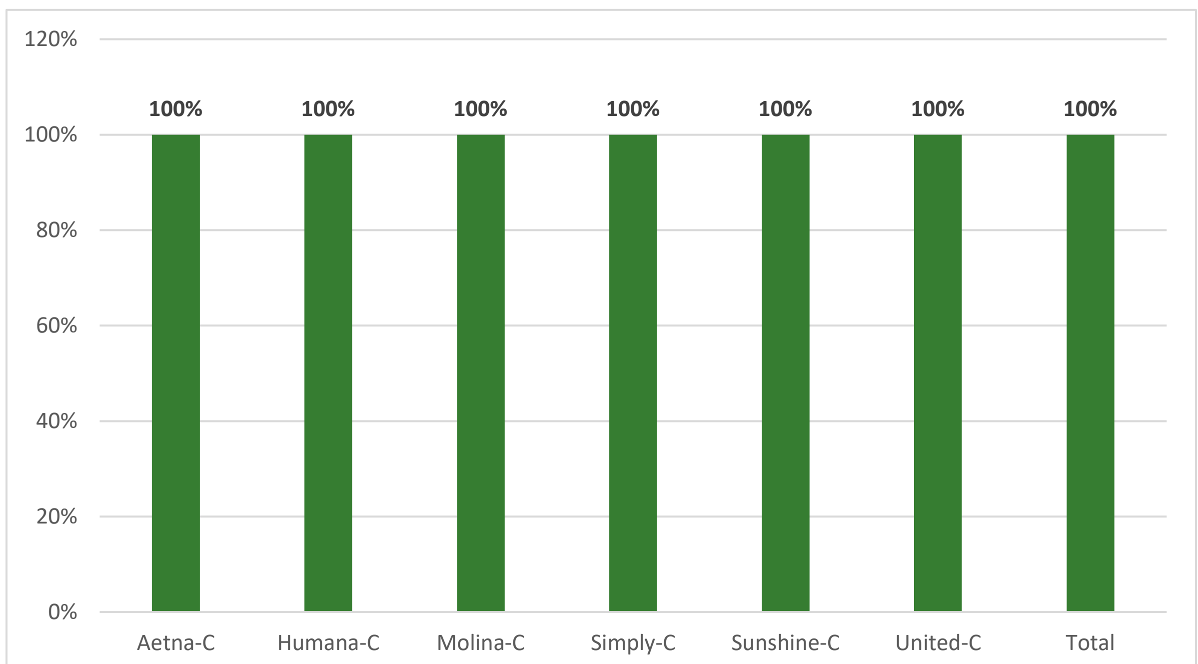
Compliance with Standards

This year's technical report presents the findings and required actions HSAG received from the Agency's compliance reviews. The Agency conducted the compliance reviews, documented the findings, and developed recommendations for *Not Met* elements. Compliance review results were not validated by HSAG. The Agency will monitor plan remediation efforts for any element that was scored *Not Met*.

Comprehensive Plans

Figure 2-1 presents an overall summary of the plan compliance review results for all 14 standards reviewed during the 2023 compliance review for the following comprehensive plans: Aetna-C, Humana-C, Molina-C, Simply-C, Sunshine-C, and United-C.

Figure 2-1—Overall Compliance Ratings by Comprehensive Plan for Three-Year Period: SFY 2022–2024



The following tables present an overall summary of the plan compliance review results for the following comprehensive plans: Aetna-C, Humana-C, Molina-C, Simply-C, Sunshine-C, and United-C.

Aetna-C

Table 2-4 presents a summary of compliance review results for Aetna-C.

Table 2-4—Aetna-C Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.242	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D=*Deemed*, ***M***=*Met*, ***NM***=*Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Humana-C

Table 2-5 presents a summary of compliance review results for Humana-C.

Table 2-5—Humana-C Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D=*Deemed*, ***M***=*Met*, ***NM***=*Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Molina-C

Table 2-6 presents a summary of compliance review results for Molina-C.

Table 2-6—Molina-C Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D=*Deemed*, ***M***=*Met*, ***NM***=*Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Simply-C

Table 2-7 presents a summary of compliance review results for Simply-C.

Table 2-7—Simply-C Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Sunshine-C

Table 2-8 presents a summary of compliance review results for Sunshine-C.

Table 2-8—Sunshine-C Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

United-C

Table 2-9 presents a summary of compliance review results for United-C.

Table 2-9—United-C Compliance Review Scores for the Three-Year Period: SFY 2022–2024

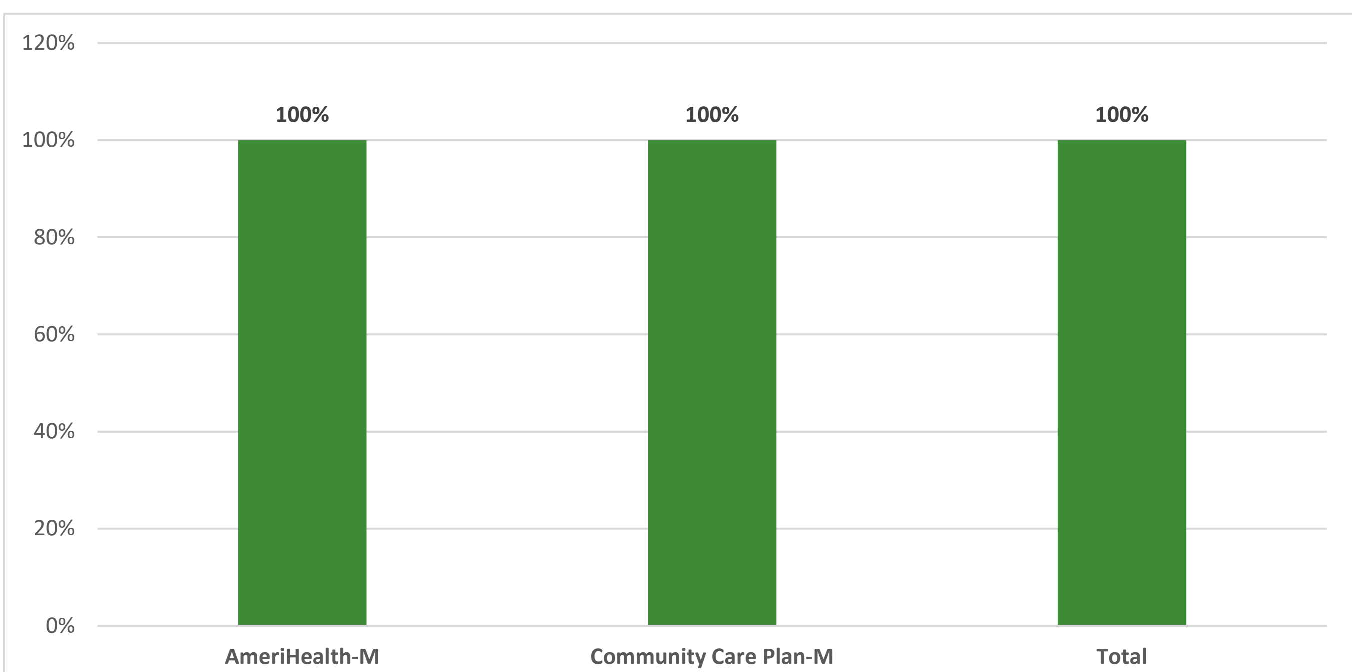
Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

MMA Plans

Figure 2-2 presents an overall summary of the plan compliance review results for all 14 standards reviewed during the 2023 compliance review for the following MMA plans: AmeriHealth-M and Community Care Plan-M.

Figure 2-2—Overall Compliance Ratings by MMA Plan for the Three-Year Period: SFY 2022–2024



The following tables present an overall summary of the plan compliance review results for AmeriHealth-M and Community Care Plan-M.

AmeriHealth-M

Table 2-10 presents a summary of the compliance review results for AmeriHealth-M.

Table 2-10—AmeriHealth-M Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D=*Deemed*, ***M***=*Met*, ***NM***=*Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Community Care Plan-M

Table 2-11 presents a summary of the compliance review results for Community Care Plan-M.

Table 2-11—Community Care Plan-M Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

LTC Plus Plan

Florida Community Care-L

Table 2-12 presents a summary of the compliance review results for Florida Community Care-L.

Table 2-12—Florida Community Care-L Compliance Review Scores for the Three-Year Period: SFY 2022–2024

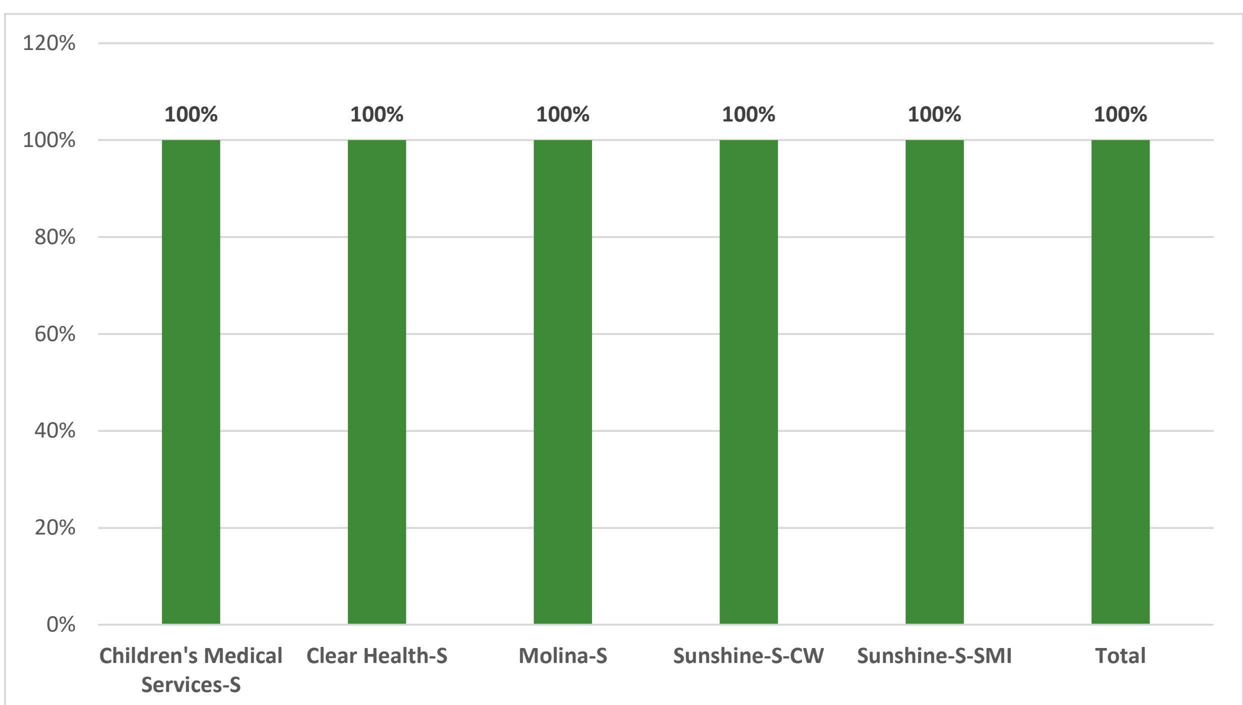
Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	7	14	0	100%
IV	Emergency and Poststabilization Services	438.114	12	0	12	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	6	10	0	100%
VI	Coordination and Continuity of Care	438.208	9	2	7	0	100%
VII	Coverage and Authorization of Services	438.210	20	1	19	0	100%
VIII	Provider Selection	438.214	10	1	9	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	3	5	0	100%
XIII	Grievance and Appeal Systems	438.228	28	0	28	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**24**	**144**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Specialty Plans

Figure 2-3 presents an overall summary of the plan compliance review results for all 14 standards reviewed during the 2022 compliance review for the following specialty plans: Children's Medical Services-S, Clear Health-S, Molina-S, Sunshine-S-CW, and Sunshine-S-SMI

Figure 2-3—Overall Compliance Ratings by Specialty Plan for the Three-Year Period: SFY 2022–2024



The following tables present an overall summary of the plan compliance review results for the following specialty plans: Children's Medical Services-S, Clear Health-S, Molina-S, Sunshine-S-CW, and Sunshine-S-SMI.

Children's Medical Services–S

Table 2-13 presents a summary of compliance review results for Children's Medical Services-S.

Table 2-13—Children's Medical Services–S Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Clear Health-S

Table 2-14 presents a summary of the compliance review results for Clear Health-S.

Table 2-14—Clear Health-S Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Molina-S

Table 2-15 presents a summary of the compliance review results for Molina-S.

Table 2-15—Molina Health-S Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D*=Deemed,* ***M****=Met*, ***NM****=Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Sunshine-S-CW

Table 2-16 presents a summary of the compliance review results for Sunshine-S-CW.

Table 2-16—Sunshine-S-CW Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D=*Deemed*, ***M***=*Met*, ***NM***=*Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Sunshine-S-SMI

Table 2-17 presents a summary of the compliance review results for Sunshine S-SMI.

Table 2-17—Sunshine-S-SMI Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	8	0	8	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	7	0	7	0	100%
III	Member Information	438.10	21	15	6	0	100%
IV	Emergency and Poststabilization Services	438.114	12	1	11	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	16	8	8	0	100%
VI	Coordination and Continuity of Care	438.208	9	6	3	0	100%
VII	Coverage and Authorization of Services	438.210	20	2	18	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	3	0	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	8	4	4	0	100%
XIII	Grievance and Appeal Systems	438.228	28	8	20	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**168**	**50**	**118**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Dental Plans

Figure 2-4 presents an overall summary of the plan compliance review results for all 14 standards reviewed during the 2022 compliance review for the following dental plans: DentaQuest-D, Liberty-D, and MCNA-D.

Figure 2-4—Overall Compliance Ratings by Dental Plan for the Three-Year Period: SFY 2022–2024

DentaQuest-D

Table 2-18 presents a summary of the compliance review results for DentaQuest-D.

Table 2-18—DentaQuest–D Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	7	0	7	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	6	0	6	0	100%
III	Member Information	438.10	20	11	9	0	100%
IV	Emergency and Poststabilization Services	438.114	11	1	10	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	13	3	10	0	100%
VI	Coordination and Continuity of Care	438.208	9	2	7	0	100%
VII	Coverage and Authorization of Services	438.210	17	1	16	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	0	3	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	7	2	5	0	100%
XIII	Grievance and Appeal Systems	438.228	28	3	25	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**157**	**26**	**131**	**0**	**100%**

D*=Deemed,* ***M****=Met,* ***NM****=Not Met*

Total Elements: The total number of elements in each standard.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Liberty-D

Table 2-19 presents a summary of the compliance review results for Liberty-D.

Table 2-19—Liberty-D Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	7	0	7	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	6	0	6	0	100%
III	Member Information	438.10	20	11	9	0	100%
IV	Emergency and Poststabilization Services	438.114	11	1	10	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	13	3	10	0	100%
VI	Coordination and Continuity of Care	438.208	9	2	7	0	100%
VII	Coverage and Authorization of Services	438.210	17	1	16	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	0	3	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	7	2	5	0	100%
XIII	Grievance and Appeal Systems	438.228	28	3	25	0	100%
XIV	Program Integrity	438.608 438.610	12	0	12	0	100%
Total Compliance Score			**157**	**26**	**131**	**0**	**100%**

D=*Deemed,* ***M***=*Met*, ***NM***=*Not Met*
Total Elements: The total number of elements in each standard.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

MCNA-D

Table 2-20 presents a summary of the compliance review results for MCNA-D.

Table 2-20—MCNA-D Compliance Review Scores for the Three-Year Period: SFY 2022–2024

Standard #	Standard Name	CFR	Total Number of Elements	Number of Elements			Total Compliance Score
				D	*M*	*NM*	
I	Disenrollment Requirements and Limitations	438.56	7	0	7	0	100%
II	Enrollee Rights and Confidentiality	438.100 438.224	6	0	6	0	100%
III	Member Information	438.10	20	11	9	0	100%
IV	Emergency and Poststabilization Services	438.114	11	1	10	0	100%
V	Adequate Capacity and Availability of Services	438.206 438.207	13	3	10	0	100%
VI	Coordination and Continuity of Care	438.208	9	2	7	0	100%
VII	Coverage and Authorization of Services	438.210	17	1	16	0	100%
VIII	Provider Selection	438.214	10	2	8	0	100%
IX	Subcontractual Relationships and Delegation	438.230	4	1	3	0	100%
X	Practice Guidelines	438.236	3	0	3	0	100%
XI	Health Information Systems	438.342	10	0	10	0	100%
XII	Quality Assessment and Performance Improvement	438.330	7	2	5	0	100%
XIII	Grievance and Appeal Systems	438.228	28	3	25	0	100%
XIV	Program Integrity	438.608 438.610	12	0	11	0	100%
Total Compliance Score			**157**	**26**	**131**	**0**	**100%**

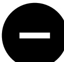
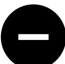
D=*Deemed*, ***M***=*Met*, ***NM***=*Not Met*

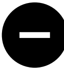
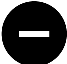
Total Elements: The total number of elements in each standard.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements. The scored tools submitted by the Agency identified desk review results, on-site results, and corrective actions made by the plans. The Total Compliance Score provided by the Agency reflects final scores after remediation.

Conclusions and Recommendations Related to Quality, Timeliness, and Access

Program-level strengths, weakness, and recommendations related to quality, timeliness, and access are presented below. For plan-specific conclusions and recommendations, please see Appendix C.

Strengths	
	Strength: The final compliance review scores for all plans (i.e., the comprehensive plans, MMA plans, LTC Plus plan, and the dental plans) were 100 percent. The final scores reflect results of plan remediation of any deficiencies identified during the compliance review. The Agency conducted follow-up reviews to determine the implementation status of the corrective actions taken to achieve full compliance.
Weaknesses and Recommendations	
	**Weakness:** Overall, opportunities for improvement exist in the Program Integrity Standard, with 14 plans implementing corrective actions after the initial compliance review for not meeting requirements for providing the most current list of owners, operators, principals, directors, officers, partners, employees, consultants, delegated entities, and/or owners with 5 percent or more of the plan's equity. Initial compliance review findings included that plans did not consistently determine if employees were eligible to work in Medicaid and on the clearinghouse roster. **Recommendations:** HSAG recommends that the Agency implement a process to monitor and require corrective action plans (CAPs) from plans identified as not meeting this program integrity requirement. HSAG recommends that the Agency consider escalating sanctions for continued or additional noncompliance with the requirement.
	**Weakness:** The compliance review findings suggest that there are continued opportunities to decrease wait times for appointments. The findings suggest an overall opportunity to improve requirements for capacity and availability of services. **Recommendations:** HSAG recommends that the Agency consider requiring the plans to include, in their annual evaluation of the effectiveness of their network development plan, all efforts taken to recruit and retain providers as well as other initiatives used to fill network gaps (telemedicine, transportation, single case agreements for non-contracted providers, etc.). HSAG also recommends that the Agency consider requiring that plans describe alternative processes implemented to decrease appointment wait times. The evaluation submission should also include information on network exception requests submitted to the Agency, particularly to address network deficiencies in rural areas.

Weaknesses and Recommendations	
	**Weakness:** During the initial compliance review, four comprehensive plans, two MMA plans, one LTC plan, and one specialty plan did not demonstrate a consistent process to exclude utilization data for covered outpatient drugs that were subject to discounts under the 340B drug pricing program, or a consistent process used to report drug utilization data necessary for the Agency to bill manufacturers for rebates no later than 45 calendar days after the end of each quarterly rebate period. **Recommendations:** HSAG recommends that the Agency consider requiring CAPs from plans failing to demonstrate a consistent process to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program, and from plans that do not have consistent processes to report drug utilization data necessary for the Agency's quarterly rebate process.
	**Weakness:** The Health Information Systems Standard was among the lowest-scoring standards for eight plans in the initial compliance review. Results suggest opportunities for improving encounter data submissions and ensuring fee schedules are current in the claims system. **Recommendations:** HSAG recommends that the Agency continue its efforts with the plans to improve encounter data submissions. HSAG also recommends that the Agency continue its process for external review of the completeness and accuracy of encounter data submissions and to identify whether improvement efforts are successful. HSAG recommends that the Agency consider requiring corrective actions from plans when encounter data submission issues are identified. Additional information provided by the Agency identified continued work to improve encounter data submissions. The Agency stated that work is being conducted by a customer service representative (CSR) team to enhance and simplify the national provider identifier (NPI) mapping logic and taxonomy processes for the providers and plans. In addition, the Agency developed new monitoring tools for encounter resubmissions and is working with each plan individually to enhance its encounter submission compliance scores. The Agency stated that regular plan education is conducted on common denials. The Agency and Gainwell support the plans' submission of interchange control numbers (ICNs) requiring assistance. The plans are also encouraged to request virtual meetings regarding encounter submissions.

Performance Measures

Overview

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 Protocol 2, cited earlier in this report. HSAG reviewed the LO's independent auditing process to ensure key audit activities were performed, and validated that performance measure indicator rates were collected, reported, and calculated according to the specifications required by the state.

For the MMA program, the Agency required that the plans undergo an NCQA HEDIS Compliance Audit on the performance measures selected for reporting. All measure indicator data were audited by each plan's NCQA LO. To avoid any redundancy in the auditing process, HSAG evaluated the NCQA HEDIS Compliance Audit process for consistency with the CMS Protocol 2.

For the LTC program, the Agency required that the plans undergo a PMV audit conducted by an external audit firm in accordance with the CMS Protocol 2. However, since some of the measures required to be reported follow the HEDIS measure specifications, the Agency required that an NCQA HEDIS Compliance Audit be conducted. Based on FAR reviews, HSAG found that for the current year, all plan audits for the LTC program were conducted following the NCQA HEDIS Compliance Audit policies and procedures.

For the dental plans, all three dental plans were audited by an LO. For the current MY, all plans were fully compliant based on the LO's findings.

Data Collection

A description of the types of data obtained and an explanation of the nature of the data collected and analyzed is provided in Appendix B of this report.

Measures

Table 3-1 shows HSAG's assignment of the HEDIS MY 2022 performance measures into the domains of quality, timeliness, and access.

Table 3-1—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains

Performance Measure	Quality	Timeliness	Access
Pediatric Care			
Childhood Immunization Status—Combination 3, *Combination 7*, and *Combination 10*	✓		✓
Child and Adolescent Well-Care Visits—Total	✓		✓
Lead Screening in Children	✓	✓	
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase and *Continuation and Maintenance Phase*	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*	✓		
Immunizations for Adolescents—Combination 1 and *Combination 2*	✓		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months and *Well-Child Visits for Age 15 Months–30 Months*	✓		✓
Women's Care			
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Total	✓		
Breast Cancer Screening	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Living with Illness			
Blood Pressure Control for Patients With Diabetes	✓		
Colorectal Cancer Screening	✓		
Controlling High Blood Pressure	✓	✓	
Eye Exam for Patients With Diabetes	✓		
Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%) and *HbA1c Poor Control (>9.0%)*	✓		

Performance Measure	Quality	Timeliness	Access
Kidney Health Evaluation for Patients with Diabetes—Total	✓		
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*	✓		
Asthma Medication Ratio—Total	✓		
Behavioral Health			
Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total and *Engagement of SUD Treatment—Total*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use—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—Blood Glucose Testing—Total, Cholesterol Testing—Total, and *Blood Glucose and Cholesterol Testing—Total*	✓		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✓		✓
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services—Total		✓	✓
Appropriate Treatment and Utilization			
Ambulatory Care (per 1,000 Member Years)—Emergency Department Visits—Total	NA	NA	NA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	✓		

Plan Names and Enrollment

Some tables in this section include abbreviated names of plans. Full plan names can be found in Appendix A. In addition, plan-specific enrollment should be noted when interpreting results.

MMA Program

The Agency required that each plan undergo an NCQA HEDIS Compliance Audit of the performance measures selected for reporting. These audits were performed by NCQA LOs in 2023 on data collected during 2022.

Statewide Results

The results sections below discuss the statewide average performance as compared to the Agency-identified performance targets and minimum performance targets, which were established based on NCQA's Quality Compass®,[3-1] national Medicaid All Lines of Business 75th and 25th percentiles, respectively, for HEDIS MY 2021, and statewide rate increases or decreases from MY 2021 to MY 2022.

These performance targets are inclusive of the national Medicaid trends (i.e., if the rate increased from MY 2021 to MY 2022 that increase will be reflected in the national Medicaid percentiles) and therefore ensure comparability of the Florida Medicaid results for each applicable MY. To interpret how these results compare to national Medicaid trends, if the Florida Medicaid performance measure result met or exceeded the performance target in MY 2021 then did not meet or exceed the performance target in MY 2022, this indicates the Florida Medicaid performance did not follow the national Medicaid trend.

[3-1] Quality Compass® is a registered trademark of the NCQA.

Statewide Results—Pediatric Care

Table 3-2 displays the statewide averages calculated by HSAG for MY 2021 and MY 2022 for all measures in the Pediatric Care domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures). Cells shaded in green indicate performance rates that met or exceeded the applicable MY performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance targets for the applicable MY. To review the Pediatric Care measure indicator rates by plan, please see the Comparative Analysis section.

Table 3-2—Florida Medicaid Performance Measure Result Summary, Pediatric Care

Measure	Measure Source	MY 2021	MY 2022
Child and Adolescent Well-Care Visits			
3–11 Years	HEDIS	63.06%	62.93%
12–17 Years	HEDIS	54.29%	53.95%
18–21 Years	HEDIS	27.39%	26.65%
Total (3–21 Years)	HEDIS	55.00%	54.12%
Childhood Immunization Status			
Combination 3	HEDIS	68.80%	69.41%
Combination 7	HEDIS	60.43%	60.32%
Combination 10	HEDIS	31.47%	24.47%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication			
Initiation Phase	HEDIS	44.55%	47.12%
Continuation and Maintenance Phase	HEDIS	60.12%	60.91%
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)	HEDIS	73.66%	73.58%
Combination 2 (Meningococcal, Tdap, HPV)	HEDIS	38.56%	36.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
Body Mass Index (BMI) Percentile—Total (3–17 Years)	HEDIS	84.27%	83.74%
Counseling for Nutrition—Total (3–17 Years)	HEDIS	80.25%	77.59%
Counseling for Physical Activity—Total (3–17 Years)	HEDIS	77.64%	75.61%
Lead Screening in Children			
Lead Screening in Children	HEDIS	69.69%	65.72%
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months	HEDIS	59.53%	60.29%
Well-Child Visits for Age 15 Months–30 Months	HEDIS	72.09%	71.91%

Indicates that the performance measure indicator rate for the applicable MY met or exceeded the performance target. (green)

Indicates that the performance measure indicator rate for the applicable MY ranked below the minimum performance target. (yellow)

In MY 2022, four of the 17 (23.5 percent) statewide average rates within the Pediatric Care domain met or exceeded the performance targets (*Childhood Immunization Status—Combination 3, Childhood*

Immunization Status—Combination 7, Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase and *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase)*. One of the 17 (approximately 5.8 percent) statewide average rates within the Pediatric Care domain fell below the MY 2022 minimum performance targets, demonstrating opportunities for statewide improvements in the Pediatric Care domain *(Childhood Immunization Status—Combination 10).*

Statewide Results—Women's Care

Table 3-3 displays the statewide averages calculated by HSAG for MY 2021 and MY 2022 for all measures in the Women's Care domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures). Cells shaded in yellow indicate performance rates that fell below the minimum performance targets for the applicable MY. To review the Women's Care measure indicator rates by plan, please see the Comparative Analysis section.

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

Measure	Measure Source	MY 2021	MY 2022
Breast Cancer Screening			
Breast Cancer Screening	HEDIS	48.62%	50.36%
Cervical Cancer Screening			
Cervical Cancer Screening	HEDIS	55.21%	56.12%
Chlamydia Screening in Women			
Total (16–24 Years)	HEDIS	61.07%	62.43%
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	HEDIS	77.68%	79.11%
Postpartum Care	HEDIS	70.43%	73.51%

Indicates that the performance measure indicator rate for the applicable MY ranked below the minimum performance target.

None of the five (zero percent) statewide average rates in the Women's Care domain met or exceeded the MY 2022 performance targets. One of five (20 percent) statewide average rates fell below the MY 2022 minimum performance target, demonstrating opportunities for statewide improvement in the Women's Care domain *(Prenatal and Postpartum Care—Timelines of Prenatal Care).*

Statewide Results—Living with Illness

Table 3-4 displays the statewide averages calculated by HSAG for MY 2021 and MY 2022 for all measures in the Living with Illness domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures). Cells shaded in green indicate performance rates that met or exceeded the applicable MY performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for the applicable MY. To review the Living with Illness measure indicator rates by plan, please see the Comparative Analysis section.

Table 3-4—Florida Medicaid Performance Measure Result Summary, Living with Illness

Measure	Measure Source	MY 2021	MY 2022
Asthma Medication Ratio			
Total (5–64 Years)	HEDIS	71.15%	72.16%
Blood Pressure Control for Patients With Diabetes			
Blood Pressure Control for Patients With Diabetes	HEDIS	55.29%	63.14%
Controlling High Blood Pressure			
Controlling High Blood Pressure	HEDIS	58.22%	63.19%
Eye Exam for Patients With Diabetes			
Eye Exam for Patients With Diabetes	HEDIS	45.86%	45.94%
Hemoglobin A1c Control for Patients with Diabetes			
HbA1c Control (<8.0%)	HEDIS	44.56%	49.26%
*HbA1c Poor Control (>9.0%)**	HEDIS	48.90%	43.53%
Kidney Health Evaluation for Patients with Diabetes			
Ages 18–64 Years	HEDIS	34.97%	36.13%
Ages 65–74 Years	HEDIS	40.89%	45.91%
Ages 75–85 Years	HEDIS	41.78%	47.29%
Total (Ages 18–85 Years)	HEDIS	36.00%	37.34%
Medical Assistance with Smoking and Tobacco Use Cessation			
Advising Smokers and Tobacco Users to Quit—Total (18+ Years)	HEDIS	60.49%	65.68%
Discussing Cessation Medications—Total (18+ Years)	HEDIS	50.51%	46.93%
Discussing Cessation Strategies—Total (18+ Years)	HEDIS	42.71%	53.81%

** Lower rates indicate better performance for this measure.*
— Indicates that the rate is not presented because the plan was not required to report the measure for MY 2022.
[green] Indicates that the performance measure indicator rate for the applicable MY met or exceeded the performance target.
[yellow] Indicates that the performance measure indicator rate for the applicable MY ranked below the minimum performance target.

In MY 2022 three of the 13 (approximately 23.1 percent) statewide average rates within the Living with Illness domain met or exceeded the applicable MY performance targets *(Asthma Medication Ratio—Total (5–64 Years), Kidney Health Evaluation for Patients with Diabetes—Ages 65–74 Years,* and *Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total)*. One of the 13 (approximately 7.7 percent) MY 2022 statewide average rates fell below the minimum performance target (*Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total*).

Statewide Results—Behavioral Health

Table 3-5 displays the statewide averages calculated by HSAG for MY 2021 and MY 2022 for all measures in the Behavioral Health domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures). Cells shaded in yellow indicate performance rates that fell below the minimum performance targets for the applicable MY. To review the Behavioral Health measure indicator rates by plan, please see the Comparative Analysis section.

Table 3-5—Florida Medicaid Performance Measure Result Summary, Behavioral Health

Measure	Measure Source	MY 2021	MY 2022
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS	60.22%	58.30%
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	77.86%	78.05%
Antidepressant Medication Management			
Effective Acute Phase Treatment	HEDIS	59.93%	58.95%
Effective Continuation Phase Treatment	HEDIS	42.24%	40.52%
Follow-Up After Emergency Department Visit for Substance Use*			
7-Day Follow-Up—Total (13+ Years)	HEDIS	—	16.97%
30-Day Follow-Up—Total (13+ Years)	HEDIS	—	26.75%
Follow-Up After Emergency Department Visit for Mental Illness			
7-Day Follow-Up—Total (6+ Years)	HEDIS	28.80%	27.98%
30-Day Follow-Up—Total (6+ Years)	HEDIS	42.42%	41.57%
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Total (6+ Years)	HEDIS	25.61%	29.85%
30-Day Follow-Up—Total (6+ Years)	HEDIS	43.57%	49.89%
Initiation and Engagement of Substance Use Disorder (SUD) Treatment*			
Initiation of SUD Treatment—Total—Total (13+ Years)	HEDIS	—	43.96%
Engagement of SUD Treatment—Total—Total (13+ Years)	HEDIS	—	7.56%
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose Testing—Total (1–17 Years)	HEDIS	51.20%	51.78%
Cholesterol Testing—Total (1–17 Years)	HEDIS	36.53%	36.68%
Blood Glucose and Cholesterol Testing—Total (1–17 Years)	HEDIS	34.59%	35.02%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total (1–17 Years)	HEDIS	61.34%	59.29%

Indicates that the performance measure indicator rate for the applicable MY ranked below the minimum performance target.

**An asterisk notes that the indicator rates could not be compared to the MY 2021 Medicaid national benchmarks because of a break in trending recommended by NCQA due to significant changes in the measure specifications.*

None of the 16 (0 percent) statewide average rates within the Behavioral Health domain met or exceeded the applicable MY 2022 performance targets. Four of 16 (25 percent) MY 2022 statewide average rates fell below the minimum performance targets, demonstrating opportunities for statewide improvement in the Behavioral Health domain *(Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years), Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years), Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years).*

Statewide Results—Access/Availability of Care

Table 3-6 displays the statewide averages calculated by HSAG for MY 2021 and MY 2022 for the one measure in the Access/Availability of Care domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures). Cells shaded in yellow indicate performance rates that fell below the minimum performance targets for the applicable MY. To review the Access/Availability of Care measure indicator rates by plan, please see the Comparative Analysis section.

Table 3-6—Florida Medicaid Performance Measure Result Summary, Access/Availability of Care

Measure	Measure Source	MY 2021	MY 2022
Adults' Access to Preventive/Ambulatory Health Services			
Total (20+ Years)	HEDIS	67.96%	62.56%

Indicates that the performance measure indicator rate for the applicable MY ranked below the minimum performance target.

The only statewide average rate in the Access/Availability of Care domain fell below the minimum performance target, demonstrating opportunities for statewide improvements in the Access/Availability of Care domain.

Statewide Results—Appropriate Treatment and Utilization

Table 3-7 displays the statewide averages calculated by HSAG for MY 2021 and MY 2022 for the two measures in the Appropriate Treatment and Utilization domain, which have performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance targets for the applicable MY. To review the Appropriate Treatment and Utilization measure indicator rates by plan, please see the Comparative Analysis section.

Table 3-7—Florida Medicaid Performance Measure Result Summary, Appropriate Treatment and Utilization

Measure	Measure Source	MY 2021	MY 2022
Ambulatory Care (per 1,000 Member Months)			
*Emergency Department Visits—Total**	HEDIS	665.52	692.44
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis			
Total	HEDIS	—	61.59%

***** *Lower rates indicate better performance for this measure.*

Indicates that the performance measure indicator rate for the applicable MY ranked below the minimum performance target.

None of the statewide average rates met or exceeded the Agency's applicable 2022 MY performance targets in the Appropriate Treatment and Utilization domain.

Comparative Analysis—Plan-Specific Results

The Comparative Analysis section displays the plan-specific performance compared to the performance targets. Cells shaded in green indicate performance rates that met or exceeded the performance targets. Cells shaded in yellow indicate performance rates that fell below the minimum performance target for MY 2022.

Comparative Analysis—Pediatric Care

Table 3-8 shows the performance measure names and associated measure name abbreviations for measures included in the Pediatric Care domain.

Table 3-8—Pediatric Care Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Childhood Immunization Status—Combination 3	CIS-3
Childhood Immunization Status—Combination 7	CIS-7
Childhood Immunization Status—Combination 10	CIS-10
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD Medication—Initiation Phase	ADD-I
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase	ADD-C
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total (3–17 Years)	WCC-B
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total (3–17 Years)	WCC-N
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total (3–17 Years)	WCC-P
Child and Adolescent Well-Care Visits—3-11 Years	WCV-311
Child and Adolescent Well-Care Visits—12-17 Years	WCV-1217
Child and Adolescent Well-Care Visits—18-21 Years	WCV-1821
Child and Adolescent Well-Care Visits—Total (3–21 Years)	WCV-Tot
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	IMA-1
Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	IMA-2
Lead Screening in Children	LSC
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months	W30-6
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months	W30-2

Table 3-9 and Table 3-10 show the results for the plans for MY 2022 measures within the Pediatric Care domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures). Full plan names are listed in Appendix A.

Table 3-9—MY 2022 Pediatric Care Domain Performance Measure Results

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
CIS-3	72.75%	77.13%	65.21%	57.14%	77.86%	67.64%	77.13%
CIS-7	61.80%	66.91%	56.45%	45.71%	51.58%	59.61%	68.37%
CIS-10	25.06%	30.17%	26.76%	14.29%	26.52%	24.57%	35.52%
ADD-I	42.30%	47.26%	41.94%	NA	48.27%	42.99%	46.79%
ADD-C	50.00%	74.67%	NA	NA	59.62%	58.88%	62.34%
WCC-B	90.27%	91.15%	87.83%	94.48%	78.42%	93.61%	84.91%
WCC-N	87.35%	89.62%	81.51%	85.89%	73.32%	85.84%	76.16%
WCC-P	85.89%	88.85%	81.51%	79.75%	69.98%	84.93%	74.45%
WCV-311	61.85%	72.06%	66.46%	48.23%	72.35%	63.09%	68.83%
WCV-1217	53.04%	63.79%	59.29%	35.63%	64.26%	53.77%	59.16%
WCV-1821	26.95%	34.50%	33.36%	20.74%	41.14%	27.88%	34.01%
WCV-Tot	53.20%	64.14%	59.21%	33.01%	65.45%	54.60%	59.97%
IMA-1	76.16%	81.09%	77.62%	NA	77.67%	71.29%	77.62%
IMA-2	37.96%	46.32%	36.01%	NA	40.45%	31.87%	43.07%
LSC	67.08%	73.72%	70.30%	57.14%	68.86%	64.72%	68.61%
W30-6	64.31%	66.42%	64.59%	NA	37.70%	61.99%	62.76%
W30-2	76.46%	78.81%	70.38%	58.06%	81.35%	72.22%	79.65%

NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
Indicates that the rate is not presented because the plan was not required to report the measure for MY 2022.

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

Table 3-10—MY 2022 Pediatric Care Domain Performance Measure Results

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C
CIS-3	—	71.29%	67.91%	—	73.97%	67.64%
CIS-7	—	61.80%	59.47%	—	59.37%	57.91%
CIS-10	—	25.79%	22.94%	—	30.90%	20.44%
ADD-I	40.00%	46.69%	47.62%	50.87%	53.31%	46.32%
ADD-C	NA	61.37%	61.36%	60.42%	61.68%	63.64%
WCC-B	79.08%	87.10%	77.01%	76.07%	85.89%	92.21%
WCC-N	67.64%	82.24%	71.15%	67.13%	76.16%	82.97%
WCC-P	65.69%	81.51%	68.29%	65.40%	74.45%	80.54%
WCV-311	37.35%	63.49%	60.83%	56.70%	68.57%	60.94%
WCV-1217	36.76%	55.70%	51.92%	49.31%	58.47%	49.81%
WCV-1821	18.00%	28.63%	24.02%	23.96%	37.19%	23.87%

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C
WCV-Tot	26.12%	55.23%	52.23%	36.24%	63.72%	51.68%
IMA-1	46.49%	78.35%	71.51%	74.94%	74.67%	69.34%
IMA-2	20.54%	37.71%	35.85%	38.93%	38.37%	32.36%
LSC	—	64.96%	64.72%	—	72.99%	66.42%
W30-6	—	59.25%	58.30%	—	51.45%	63.86%
W30-2	—	72.20%	69.71%	—	84.11%	71.06%

NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
— Indicates that the rate is not presented because the plan was not required to report the measure for MY 2022.
Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.
Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

Within the Pediatric Care domain, AmeriHealth-M, Community Care Plan-M, Children's Medical Services Network-S, Molina-C, and Sunshine-S-CW are the highest-performing plans, with at least eight rates meeting or exceeding the performance targets. Additionally, at least seven plans met or exceeded the performance targets for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile—Total (3–17 Years)*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total (3–17 Years),* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total (3–17 Years).* Conversely, Molina-S and Clear Health-S were the lowest-performing plans, with at least six measure indicator rates falling below the minimum performance targets. Of note, four plans (Children's Medical Services Network-S, Humana-C, Sunshine-C, and United-C) had two or more measure indicator rates fall below the minimum performance targets. Eight of the 13 plans (61.5 percent) with a reportable measure rate fell below the minimum performance targets for the *Childhood Immunization Status—Combination 10.*

Comparative Analysis—Women's Care

Table 3-11 shows the performance measure names and associated measure name abbreviations for measures included in the Women's Care domain.

Table 3-11—Women's Care Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Cervical Cancer Screening—Cervical Cancer Screening	CCS
Chlamydia Screening in Women—Total (16–24 Years)	CHL
Breast Cancer Screening—Breast Cancer Screening	BCS
Prenatal and Postpartum Care—Timeliness of Prenatal Care	PPC-Pre
Prenatal and Postpartum Care—Postpartum Care	PPC-Pst

Table 3-12 and Table 3-13 show the MY 2022 results for the plans for measures within the Women's Care domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures).

Table 3-12—MY 2022 Women's Care Domain Performance Measure Results

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
CCS	55.47%	60.16%	55.72%	56.93%	—	58.15%	64.72%
CHL	65.19%	70.41%	68.83%	73.09%	49.80%	62.91%	62.88%
BCS	48.31%	49.74%	51.13%	48.59%	—	53.30%	60.96%
PPC-Pre	86.13%	82.96%	82.73%	74.27%	63.12%	78.35%	86.37%
PPC-Pst	82.00%	77.04%	75.67%	67.96%	69.50%	75.18%	78.10%

— Indicates that the rate is not presented because the plan was not required to report the measure for MY 2022.

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

Table 3-13—MY 2022 Women's Care Domain Performance Measure Results

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C
CCS	40.63%	58.88%	55.72%	50.12%	—	55.72%
CHL	62.78%	62.71%	61.99%	64.35%	NA	58.97%
BCS	39.61%	54.32%	49.39%	45.55%	—	49.44%
PPC-Pre	56.69%	82.24%	78.59%	69.34%	68.04%	80.78%
PPC-Pst	50.85%	73.48%	71.78%	68.13%	72.16%	78.10%

NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
— Indicates that the rate is not presented because the plan was not required to report the measure for MY 2022.

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

Within the Women's Care domain, Aetna-C and Molina-C were the highest-performing plan, with two or more out of five measure indicator rates meeting or exceeding the performance targets. Additionally, nine of the 13 plan rates (69.2 percent) met or exceeded the performance target for the *Chlamydia Screening in Women—Total* measure.

Conversely, Molina-S was the lowest-performing plan, with four out of the five measure indicator rates falling below the minimum performance targets. Additionally, eight plans fell below the minimum performance target for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator.

Comparative Analysis—Living with Illness

Table 3-14 shows the performance measure names and associated measure name abbreviations for measures included in the Living with Illness domain.

Table 3-14—Living with Illness Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Asthma Medication Ratio—Total	AMR
Blood Pressure Control for Patients With Diabetes	BPD
Controlling High Blood Pressure	CBP
Eye Exam for Patients With Diabetes	EED
Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%)	HBD-8
Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)	HBD-9*
Kidney Health Evaluation for Patients with Diabetes—Ages 18–64 Years	KED-18
Kidney Health Evaluation for Patients with Diabetes—Ages 65–74 Years	KED-65
Kidney Health Evaluation for Patients with Diabetes—Ages 75–85 Years	KED-75
Kidney Health Evaluation for Patients with Diabetes—Total (Ages 18–85 Years)	KED-T
Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total (18+ Years)	MSC-A
Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total (18+ Years)	MSC-M
Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total (18+ Years)	MSC-S

** Lower rates indicate better performance for this measure.*

Table 3-15 and Table 3-16 show the MY 2022 results for the plans for measures within the Living with Illness domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures).

Table 3-15—MY 2022 Living with Illness Domain Performance Measure Results

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
AMR	70.29%	77.51%	68.57%	38.55%	83.41%	68.91%	79.69%
BPD	62.77%	54.01%	51.82%	58.88%	67.15%	67.40%	68.61%
CBP	64.72%	57.18%	61.56%	60.10%	58.64%	72.26%	71.29%
EED	43.80%	36.74%	54.74%	44.53%	38.20%	53.53%	49.15%
HBD-8	46.72%	47.93%	47.20%	61.56%	29.44%	55.72%	53.53%
HBD-9*	43.55%	45.01%	44.28%	35.04%	61.56%	34.31%	40.88%
KED-T	40.57%	40.68%	43.41%	27.53%	32.72%	41.36%	43.76%
MSC-A	NA	NA	NA	NA	NA	NA	NA
MSC-M	NA	NA	NA	NA	NA	NA	NA
MSC-S	NA	NA	NA	NA	NA	NA	NA

** Lower rates indicate better performance for this measure.*
NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
—Indicates that the rate is not presented because the plan was not required to report the measure for MY 2022.
Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target. (green)
Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target. (yellow)

Table 3-16—MY 2022 Living with Illness Domain Performance Measure Results

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C
AMR	55.39%	70.03%	72.77%	60.38%	81.43%	71.76%
BPD	54.50%	68.86%	61.80%	53.53%	NA	67.64%
CBP	58.15%	67.40%	56.45%	61.31%	NA	67.64%
EED	32.85%	51.09%	43.31%	42.82%	NA	42.58%
HBD-8	41.36%	61.56%	44.04%	39.42%	NA	52.80%
HBD-9*	53.04%	34.55%	47.69%	55.23%	NA	40.63%
KED-T	28.36%	42.88%	35.88%	31.74%	NA	33.97%
MSC-A	NA	NA	NA	NA	NA	NA
MSC-M	NA	NA	NA	NA	NA	NA
MSC-S	NA	NA	NA	NA	NA	NA

** Lower rates indicate better performance for this measure.*
— Indicates that the rate is not presented because the plan was not required to report the measure for MY 2022.
NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target. (green)
Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target. (yellow)

Within the Living with Illness domain, Simply-C was the highest-performing plan, with six out of the 13 (46.2 percent) reportable measure indicator rates meeting or exceeding the performance targets. Additionally, eight plans met or exceeded the performance target for the *Asthma Medication Ratio—Total* measure. Conversely, Molina-S and Sunshine-S-SMI were the lowest-performing plans, with four or more rates falling below the minimum performance targets.

Comparative Analysis—Behavioral Health

Table 3-17 shows the performance measure names and associated measure name abbreviations for measures included in the Behavioral Health domain.

Table 3-17—Behavioral Health Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Adherence to Antipsychotic Medications for Individuals with Schizophrenia—Adherence to Antipsychotic Medications for Individuals With Schizophrenia	SAA
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	SSD
Antidepressant Medication Management—Effective Acute Phase Treatment	AMM-A
Antidepressant Medication Management—Effective Continuation Phase Treatment	AMM-C
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up —Total (13+ Years)	FUA-7
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up —Total (13+ Years)	FUA-30
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)	FUM-7
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)	FUM-30
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)	FUH-7
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)	FUH-30
Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)	IET-I
Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)	IET-E
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years)	APM-B
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (1–17 Years)	APM-C
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (1–17 Years)	APM-BC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)	APP

Table 3-18 and Table 3-19 show the MY 2022 results for the plans for measures within the Behavioral Health domain and whether performance met or exceeded, or was below, the performance targets (for applicable measures).

Table 3-18—MY 2022 Behavioral Health Domain Performance Measure Results

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
SAA	56.72%	55.36%	51.56%	44.44%	58.97%	62.13%	63.58%
SSD	81.02%	78.54%	79.01%	93.75%	72.75%	81.97%	82.27%
AMM-A	52.21%	51.20%	63.81%	54.67%	57.55%	54.72%	56.52%
AMM-C	35.64%	33.83%	40.00%	37.11%	37.41%	38.70%	42.63%
FUA-7*	15.24%	21.98%	15.69%	16.92%	19.74%	18.78%	19.64%
FUA-30*	21.90%	29.31%	23.53%	31.95%	28.95%	30.97%	25.89%
FUM-7	26.54%	19.08%	21.95%	11.69%	40.78%	28.47%	30.95%
FUM-30	35.80%	33.59%	36.59%	24.68%	56.88%	45.89%	45.83%
FUH-7	29.71%	34.17%	37.08%	18.82%	40.95%	33.72%	31.99%
FUH-30	49.43%	54.68%	57.30%	32.23%	66.14%	54.80%	53.60%
IET-I*	41.28%	44.85%	37.72%	55.25%	50.87%	40.93%	40.49%
IET-E*	8.43%	6.86%	4.82%	9.65%	8.04%	7.28%	7.54%
APM-B	57.03%	51.93%	66.67%	NA	53.61%	49.23%	54.22%
APM-C	38.96%	38.67%	51.85%	NA	38.33%	36.58%	35.56%
APM-BC	38.96%	36.46%	50.00%	NA	36.73%	34.38%	34.67%
APP	65.41%	68.60%	48.39%	NA	52.93%	64.39%	77.50%

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
**An asterisk notes that the indicator rates could not be compared to the MY 2021 Medicaid national benchmarks because of a break in trending recommended by NCQA due to significant changes in the measure specifications.*

Table 3-19—MY 2022 Behavioral Health Domain Performance Measure Results

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C
SAA	53.85%	66.54%	61.24%	52.15%	NA	67.93%
SSD	71.18%	78.94%	78.94%	76.03%	87.14%	79.82%
AMM-A	55.41%	62.92%	59.96%	58.29%	54.55%	64.54%
AMM-C	37.18%	44.63%	40.10%	39.72%	29.09%	45.47%
FUA-7*	14.83%	16.58%	15.07%	18.08%	20.16%	17.02%
FUA-30*	22.69%	28.53%	22.75%	28.66%	36.29%	25.38%
FUM-7	26.46%	33.09%	27.58%	23.71%	39.36%	29.64%
FUM-30	37.04%	48.06%	39.48%	35.34%	62.77%	42.29%
FUH-7	20.55%	34.38%	28.83%	25.08%	41.83%	28.36%
FUH-30	38.75%	54.97%	49.09%	42.93%	68.34%	46.47%
IET-I*	53.06%	39.72%	41.82%	51.10%	54.25%	40.41%
IET-E*	6.32%	8.51%	7.05%	8.38%	8.33%	6.59%
APM-B	52.32%	51.48%	47.28%	55.93%	55.37%	52.48%
APM-C	35.02%	35.66%	33.30%	36.70%	41.72%	37.21%

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C
APM-BC	35.02%	34.08%	31.49%	35.14%	39.76%	36.30%
APP	59.38%	61.70%	58.45%	55.02%	66.32%	49.91%

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.

**An asterisk notes that the indicator rates could not be compared to the MY 2021 Medicaid national benchmarks because of a break in trending recommended by NCQA due to significant changes in the measure specifications.*

Within the Behavioral Health domain, Community Care Plan-M was the highest-performing plan, with three measure indicator rates meeting or exceeding the performance targets. Conversely, Clear Health-S and Molina-S were the lowest-performing plans, with at least seven measure indicator rates falling below the minimum performance targets.

Comparative Analysis—Access/Availability of Care

Table 3-20 shows the performance measure name and associated measure name abbreviation for the one measure included in the Access/Availability of Care domain.

Table 3-20—Access/Availability of Care Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Adults' Access to Preventive/Ambulatory Health Services—Total	AAP

Table 3-21 and Table 3-22 show the MY 2022 results for the plans for the one measure within the Access/Availability of Care domain and whether performance met or exceeded, or was below, the performance target.

Table 3-21—MY 2022 Access/Availability of Care Domain Performance Measure Results

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
AAP	57.99%	58.67%	49.12%	75.65%	70.37%	65.23%	65.61%

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

Table 3-22—MY 2022 Access/Availability of Care Domain Performance Measure Results

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C
AAP	63.37%	60.00%	60.11%	70.49%	65.28%	65.32%

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

Within the Access/Availability of Care domain performance measure results, none of the plans met or exceeded the performance target for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator. Additionally, 12 of the 13 (approximately 92.3 percent) plans with a reportable measure rate fell below the minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure.

Comparative Analysis—Appropriate Treatment and Utilization

Table 3-23 shows the performance measure name and associated measure name abbreviation for two measures included in the Appropriate Treatment and Utilization domain.

Table 3-23—Appropriate Treatment and Utilization Domain Performance Measure Abbreviations

Performance Measure	Abbreviation
Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total	AMB-E
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	AAB

Table 3-24 and Table 3-25 show the MY 2022 results for the plans for the two measures within the Appropriate Treatment and Utilization domain and whether performance was below the performance targets.

Table 3-24—MY 2022 Appropriate Treatment and Utilization Domain Performance Measure Results

Measure	AET-C	AMH-M	CCP-M	CHA-S	CMS-S	HUM-C	MOL-C
AMB-E*	630.72	572.24	561.18	1,462.72	707.81	705.63	616.50
AAB	69.24%	59.60%	70.10%	NA	50.22%	60.91%	65.53%

NA indicates that the plan followed the specifications, but the denominator was too small to report a valid rate.
** Lower rates indicate better performance for this measure.*

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

Table 3-25—MY 2022 Appropriate Treatment and Utilization Domain Performance Measure Results

Measure	MOL-S	SIM-C	SUN-C	SUN-S-SMI	SUN-S-CW	UNI-C
AMB-E*	1,372.55	621.68	675.77	1,306.99	543.26	702.09
AAB	46.35%	64.65%	60.86%	44.34%	65.16%	61.62%

** Lower rates indicate better performance for this measure.*
— Indicates that the rate is not presented because the plan was not required to report the measure for MY 2022.

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Indicates that the performance measure indicator rate for MY 2022 ranked below the minimum performance target.

Within the Appropriate Treatment and Utilization domain, five out of the 13 (approximately 38.5 percent) plans met or exceeded the performance target for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* measure indicator.

Conversely, four of the 13 (30.8 percent) plans met or exceeded the performance target for the *Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total* indicator.

LTC Program

The Agency contracted with six comprehensive plans and one LTC Plus plan to provide LTC services to Medicaid enrollees. The plans were required to report 15 performance measure indicators for SFY 2022–2023 using 2022 data. For four reported LTC MLTSS/HEDIS measures (with a total of seven measure indicators), the Agency established performance targets of 85 percent for each measure indicator. Plans underwent a PMV audit to ensure that the rates calculated and reported for these measures were valid and accurate. The Agency required that an NCQA HEDIS Compliance Audit be conducted for all plans. All audits were conducted by LOs.

Table 3-26 displays the LTC program statewide averages for MY 2021 and MY 2022 for all measures in the LTC program and whether performance met or exceeded, or was below, the performance targets (for applicable measures). Cells shaded in green indicate performance rates that met or exceeded the performance targets. To review the LTC measure indicator rates by plan, please see the Comparative Analysis section.

LTC Program Results

Table 3-26—Florida Medicaid LTC Program Statewide Averages

Measure	Measure Source	MY 2021	MY 2022
Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update			
Assessment of Core Elements	HEDIS	87.80%	91.11%
Assessment of Supplemental Elements	HEDIS	87.65%	90.53%
LTSS Comprehensive Care Plan and Update			
Care Plan with Core Elements	HEDIS	90.98%	92.90%
Care Plan with Supplemental Elements	HEDIS	90.84%	92.78%
LTSS Shared Care Plan with Primary Care Practitioner (PCP)			
Shared Care Plan with PCP	HEDIS	86.53%	82.67%
LTSS Reassessment/Care Plan Update After Inpatient Discharge			
Reassessment After Inpatient Discharge	HEDIS	44.77%	45.50%
Reassessment and Care Plan Update After Inpatient Discharge	HEDIS	37.99%	41.06%
***Screening, Risk Assessment, and Plan of Care to Prevent Future Falls*[1]**			
Falls Part 1—Screening	CMS/Mathematica	97.95%	94.60%
Falls Part 2—Falls Risk Assessment	CMS/Mathematica	91.30%	98.93%
Falls Part 2—Plan of Care for Falls	CMS/Mathematica	66.81%	77.43%
***LTSS Admission to an Institution from the Community*[1]**			
Short-Term Stay—Total (18+ Years)	CMS/Mathematica	18.43	44.24
Medium-Term Stay—Total (18+ Years)	CMS/Mathematica	7.29	10.77
Long-Term Stay—Total (18+ Years)	CMS/Mathematica	18.62	31.25

Measure	Measure Source	MY 2021	MY 2022
LTSS Minimizing Institutional Length of Stay[1]			
LTSS Minimizing Institutional Length of Stay	CMS/Mathematica	16.28%	12.42%
LTSS Successful Transition After Long-Term Institutional Stay[1]			
LTSS Successful Transition After Long-Term Institutional Stay—Observed Rate	CMS/Mathematica	17.03%	12.77%

[1] *Indicates a performance target was not established by the Agency. Rate is displayed for information only.*

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Of the seven measure indicators for which performance targets were established, four statewide rates in the LTC program met or exceeded the performance targets *(LTSS Comprehensive Assessment and Update—Assessment of Core Elements, LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements, LTSS Comprehensive Care Plan and Update—Care Plan with Core Elements* and *LTSS Comprehensive Care Plan and Update—Care Plan with Supplemental Elements).*

Comparative Analysis

Table 3-27 shows the performance measure name and associated measure name abbreviation for the measures reported by the LTC plans.

Table 3-27—LTC Performance Measure Abbreviations

Performance Measure	Abbreviation
LTSS Comprehensive Assessment and Update—Assessment of Core Elements	CAU-1
LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements	CAU-2
LTSS Comprehensive Care Plan and Update—Care Plan with Core Elements	CPU-1
LTSS Comprehensive Care Plan and Update—Care Plan with Supplemental Elements	CPU-2
LTSS Shared Care Plan with Primary Care Practitioner (PCP)—Shared Care Plan with PCP	SCP
LTSS Reassessment/Care Plan Update After Inpatient Discharge—Reassessment After Inpatient Discharge	UIC-1
LTSS Reassessment/Care Plan Update After Inpatient Discharge—Reassessment and Care Plan Update After Inpatient Discharge	UIC-2
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 1—Screening	PFF-1
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 2—Falls Risk Assessment	PFF-2
Screening, Risk Assessment, and Plan of Care to Prevent Future Falls—Falls Part 2—Plan of Care for Falls	PFF-3
LTSS Admission to an Institution from the Community—Short-Term Stay—Total (18+ Years)	AIC-S
LTSS Admission to an Institution from the Community—Medium-Term Stay—Total (18+ Years)	AIC-M
LTSS Admission to an Institution from the Community—Long-Term Stay—Total (18+ Years)	AIC-L
LTSS Minimizing Institutional Length of Stay	MIS
LTSS Successful Transition After Long-Term Institutional Stay	TIS

Table 3-28 shows the results for MY 2022 LTC performance measures reported by the plans and whether performance met or exceeded, or was below, the performance targets (for applicable measures). Cells shaded in green indicate performance rates that met or exceeded the performance targets. Note that the six comprehensive plans serve LTC populations and therefore report LTC measure performance.

Table 3-28—MY 2022 LTC Performance Measure Results

Measure	AET-C	FCC-L	HUM-C	MOL-C	SIM-C	SUN-C	UNI-C
CAU-1	91.48%	92.94%	95.38%	93.19%	96.35%	85.16%	87.83%
CAU-2	91.48%	92.94%	93.19%	93.19%	96.35%	85.16%	87.59%
CPU-1	100%	92.94%	85.89%	99.51%	98.54%	96.84%	87.59%
CPU-2	100%	92.94%	85.40%	99.51%	98.54%	96.84%	87.59%
SCP	99.51%	85.64%	73.97%	98.54%	93.43%	86.62%	63.99%
UIC-1	32.36%	25.69%	40.66%	63.41%	68.13%	48.66%	30.90%
UIC-2	28.47%	25.69%	32.58%	63.41%	65.21%	46.72%	22.87%
PFF-1	100%	96.59%	97.32%	99.76%	100%	82.24%	96.84%
PFF-2	100%	96.35%	98.96%	97.01%	100%	99.03%	96.59%
PFF-3	58.86%	90.51%	97.39%	97.01%	79.81%	82.97%	49.39%
AIC-S	52.40	26.71	0.83	11.93	3.66	90.48	55.54
AIC-M	24.85	16.00	1.23	8.87	7.37	18.58	10.05
AIC-L	40.47	30.68	68.00	14.38	6.19	28.74	4.28
MIS	11.49%	29.25%	27.74%	5.26%	33.27%	6.75%	14.86%
TIS	8.59%	12.12%	0.78%	8.00%	8.43%	6.11%	77.37%

Indicates that the performance measure indicator rate for MY 2022 met or exceeded the performance target.

Within the LTC program, Aetna-C, Florida Community Care-L, Molina-C, Simply-C, and Sunshine-C were the highest-performing plans, with five measure indicator rates meeting or exceeding the performance targets.

Dental Plans

The Agency contracted with three dental plans to provide dental services to Medicaid enrollees. The dental plans were required to report 12 performance measure indicators for SFY 2022–2023 using 2022 data. The three dental plans were audited by an LO. Plan-specific targets were established for one dental measure included in this report, as discussed in the Comparative Analysis section. Table 3-29 displays the dental plan statewide averages for MY 2021 and MY 2022.

Dental Statewide Results

Table 3-29—Florida Dental Plan Statewide Averages

Measure	Measure Source	MY 2021	MY 2022
Annual Dental Visit[1]			
Total (2–20 Years)	HEDIS	42.95%	41.91%
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults			
*Total**	Dental Quality Alliance	19.66	22.61
Oral Evaluation, Dental Services			
Total (0–20 Years)	CMS Child Core Set	35.74%	34.07%
Topical Fluoride for Children			
Dental or Oral Health Services—Total (1–20 Years)	CMS Child Core Set	23.63%	12.58%
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children			
Total (per 100,000 Member Months)—Total (0–20 Years)	Dental Quality Alliance	5.05	4.43
Follow-Up After Emergency Department Visits for Dental Caries in Children			
7-Day Follow-Up—Total (0–20 Years)	Dental Quality Alliance	22.87%	28.00%
30-Day Follow-Up—Total (0–20 Years)	Dental Quality Alliance	40.82%	44.00%
Caries Risk Documentation			
Total	Dental Quality Alliance	6.29%	6.86%
Follow-Up After Dental-Related Emergency Department Visits			
Total	Agency-Defined	35.77%	30.71%
Sealant Receipt on Permanent First Molars			
At Least One Sealant	CMS Child Core Set	37.84%	48.08%
All Four Permanent First Molars	CMS Child Core Set	24.37%	33.82%
Treatment Services (Pediatric Measure)			
Total	Dental Quality Alliance	17.64%	16.62%

[1] Indicates a plan-specific target was identified by the Agency.
** Lower rates indicate better performance for this measure.*

Six statewide rates demonstrated improvement from MY 2021 to MY 2022. Two statewide average rates (Sealant Receipt on Permanent First Molars—At Least One Sealant and Sealant Receipt on Permanent First Molars—All Four Permanent First Molars) demonstrated an increase of more than 9 percentage points from the prior MY. Conversely, the statewide average rates for Topical Fluoride for Children—Dental or Oral Health Services—Total (1–20 Years) measure indicator demonstrated a decline of more than 11 percentage points from MY 2021 to MY 2022.

Dental Comparative Analysis

Table 3-30 shows the performance measure names and associated measure name abbreviations for measures reported by the dental plans.

Table 3-30—Dental Performance Measure Abbreviations

Performance Measure	Abbreviation
Annual Dental Visit—Total (2–20 Years)	ADV
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults—Total	EDV-A-A
Oral Evaluation, Dental Services—Total (0–20 Years)	OEV-CH
Topical Fluoride for Children—Dental or Oral Health Services—Total (1–20 Years)	TFL-CH
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children—Total (per 100,000 Member Months)—Total (0–20 Years)	EDV-CH-A-T
Follow-Up After Emergency Department Visits for Dental Caries in Children—7-Day Follow-Up—Total (0–20 Years)	EDF-CH-A-7
Follow-Up After Emergency Department Visits for Dental Caries in Children—30-Day Follow-Up—Total (0–20 Years)	EDF-CH-A-30
Caries Risk Documentation—Total	CRD
Follow-Up After Dental-Related Emergency Department Visits—Total	FUD
Sealant Receipt on Permanent First Molars—At Least One Sealant	SFM-CH-1
Sealant Receipt on Permanent First Molars—All Four Permanent First Molars	SFM-CH-2
Treatment Services (Pediatric Measure)—Total	TRT-CH-A

Table 3-31 shows the results for MY 2022 measures reported by the dental plans. Plan-specific targets were established for only one measure indicator presented in this report: *Annual Dental Visit—Total*. Cells shaded in orange indicate performance rates that fell below the plan-specific performance target for MY 2022.

Table 3-31—MY 2022 Dental Performance Measure Results

Measure	DQT-D	LIB-D	MCA-D
ADV	43.27%	42.53%	38.33%
EDV-A-A	BR	38.99	38.00
OEV-CH	37.24%	33.00%	30.15%
TFL-CH	14.23%	11.44%	11.21%
EDV-CH-A-T	BR	7.85	7.72
EDF-CH-A-7	0.00%	27.39%	29.04%
EDF-CH-A-30	0.00%	45.23%	41.92%
CRD	4.15%	12.40%	3.99%
FUD	BR	32.12%	28.48%
SFM-CH-1	49.94%	47.35%	45.10%
SFM-CH-2	35.02%	33.17%	32.23%
TRT-CH-A	16.66%	19.21%	12.78%

Indicates that the performance measure indicator rate for MY 2022 fell below the plan-specific performance target.
BR indicates the calculated rate was materially biased.

DentaQuest, Liberty, and MCNA fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator.

Conclusions and Recommendations Related to Quality, Timeliness, and Access

Program level strengths, weaknesses, and recommendations related to quality, timeliness, and access are presented below. For plan-specific conclusions and recommendations, please see Appendix C.

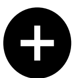
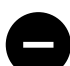
MMA Program

Pediatric Care

Strengths	
⊕	The statewide average for the *Childhood Immunization Status—Combination 3* and *Childhood Immunization Status—Combination 7* measure indicators met or exceeded the performance targets. The results indicate that the majority of children in the FL Medicaid program received *Combination 3* (DTap, IPV, MMR, HiB, HepB, VZV and PCV) and *Combination 7* (DTap, IPV, MMR, HiB, HepB, VZV, PCV, HepA, and RV) vaccines.
⊕	The statewide average for *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase* and *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase* measure indicators met or exceeded the performance targets. The results from *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation Phase* indicate that the majority of children in the FL Medicaid program between 6 and 12 years of age who were diagnosed with ADHD had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication. The results from *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation and Maintenance Phase* also indicate that children between 6 and 12 years of age who had a prescription for ADHD medication remained on the medication for at least 210 days and had at least two follow-up visits with a practitioner in the nine months after the Initiation Phase.
Weaknesses and Recommendations	
⊖	**Weakness:** The statewide average for *Childhood Immunization Status—Combination 10* fell below the performance measure target. **Recommendations:** HSAG recommends that the plans identify best practices for ensuring children receive medically appropriate preventive influenza vaccinations. Plans should consider whether there are disparities within their populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving medically appropriate influenza immunizations, plans

Weaknesses and Recommendations	
⊖	should implement appropriate interventions to improve the immunization rates. Implementations could include extended office hours, disseminating educational materials, and providing transportation and/or mobile clinics for members with transportation barriers or rural areas. Additionally, plans should review immunization data to identify specific immunizations(s) that were more apt to not be administered.
⊖	**Weakness:** The statewide average for *Lead Screening in Children* demonstrated a decline of more than 3 percentage points from MY 2021 to MY 2022. **Recommendations:** HSAG recommends that the plans conduct a segmentation analysis of noncompliant members in the measure (e.g., break down the population by geographic region, gender, race, and/or provider) to determine why some children did not receive lead blood tests by their second birthday. Upon identification of any root causes contributing to these gaps in care, HSAG recommends that the plans implement appropriate interventions to improve the use of evidence-based practices related specifically to these pediatric screenings. Additionally, plans should confirm that providers are trained to document the applicable screening test codes needed to meet compliance. Documentation of the correct codes or verbiage in the medical record is important to meet numerator compliance.

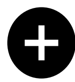
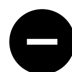
Women's Care

Strengths	
	The statewide averages for all measures/indicators increased relative to MY 2021. This increase in rates could potentially be the result of restrictions being lifted that were implemented during the public health emergency (PHE), resulting in more members completing preventive care and health screening visits. Plans should perform an analysis to understand the increase and continue to implement strategies that increased the rates in hopes to meet the performance measure target for next year.
	The statewide average rate for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator improved from MY 2021 by 3.08 percentage points which indicates that plans are implementing strategies such as incentive programs to increase the performance rates.
Weaknesses and Recommendations	
	**Weakness:** The statewide average rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator fell below the minimum performance target for a second year in a row. **Recommendations:** HSAG recommends that the plans serving the MMA program consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care, when designing strategies to improve performance rates. In addition, HSAG recommends that the plans consider whether there are disparities within the plans' populations that contribute to lower access to care. Upon identification of a root cause, plans can implement appropriate interventions to reduce barriers to care. A few strategies could include providing expanded access appointments outside of business hours, and greater utilization of telehealth. Timely and consistent monitoring of data on noncompliant members can also help close care gaps, ensuring prenatal care is achieved.

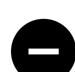
Living with Illness

	Strengths
	The statewide average for the *Asthma Medication Ratio—Total* measure indicator met or exceeded the performance target. The results suggest that members with persistent asthma are receiving recommended care and are better able to control their chronic condition.
	The statewide average rate for the *Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total (18+ Years)* indicator met or exceeded the performance target, and the statewide rate improved by 11.1 percentage points relative to MY 2021. The results suggest that members who smoked and/or used tobacco had a discussion with their medical provider on cessation strategies.
	The statewide average rates for multiple measures have shown improvement of at least 3 percent or more for the following measures: *Blood Pressure Control for Patients with Diabetes, Controlling High Blood Pressure, Hemoglobin A1c Control for Patients with Diabetes—HbA1c Control (<8.0%), Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%), Medical Assistance with Smoking and Tobacco Use Cessation—Advising Smokers and Tobacco Users to Quit—Total (18+ Years), Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total (18+ Years).*
	Weaknesses and Recommendations
	Weakness: The statewide average rate for *Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Medications—Total* (18+ Years) declined by 3.58 percentage points. **Recommendations:** HSAG recommends that the plans conduct further analysis or a focus study to determine why providers did not discuss and/or recommend cessation medications during the measurement year with their patients. Upon identification of a root cause, HSAG recommends that the plans implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation medication counseling.

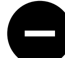
Behavioral Health

	Strengths
	The statewide average rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up —Total (6+ Years)* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* measure indicators improved by at least 3 percent relative to MY 2021 rates. The results suggest that some of the plans' strategies are helping to improve the rates and that plans should continue these implementations to help reach or exceed the performance targets in future years.
	Weaknesses and Recommendations
	**Weakness:** The statewide average rates for *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)* fell below the minimum performance targets. **Recommendations:** HSAG recommends that the plans conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Possible strategies could include validating member contact information frequently to ensure members can be reached appropriately to make the necessary appointments for follow-up and encouraging the use of telehealth services. Ensuring consistent data sharing with all inpatient BH hospitals about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that the plans enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.
	Weakness: The statewide average rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* fell below the minimum performance target. **Recommendations:** HSAG recommends that the plans evaluate opportunities to enhance care coordination to support members to access timely follow-up care after hospitalization for mental illness. Additionally, plans should partner with their contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.

LTC Program

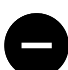
Strengths	
	Four statewide rates (*LTSS Comprehensive Assessment and Update—Assessment of Core Elements, LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements, LTSS Comprehensive Care Plan and Update—Care Plan with Core Elements,* and *LTSS Comprehensive Care Plan and Update—Care Plan with Supplemental Elements)* in the LTC program met or exceeded the performance targets. The results indicate the plans have established documentation for comprehensive assessment and care planning with members to promote the coordination of LTSS. The results also indicate that plans are conducting assessments and creating care plans with their members in a timely manner to prioritize coordination of services.
Weaknesses and Recommendations	
	**Weakness:** The *LTSS Shared Care Plan with Primary Care Practitioner (PCP)—Shared Care Plan with PCP* measure rate declined by 3.86 percentage points. **Recommendations:** HSAG recommends that the plans evaluate opportunities to enhance care coordination with PCPs. Plans should partner with their contracted providers to identify any barriers that impede the ability to share care plans with PCPs, as recommended by patient monitoring guidelines. Some initiatives could include continued LTC case manager education about documentation of information needed to meet performance measure targets, continued case management audits to ensure the highest level of documentation and the ability to quickly identify any areas that need improvement, and promptly sharing member hospitalization and/or discharge data to ensure the appropriate information is captured in a timely manner.

Access/Availability of Care

Weaknesses and Recommendations	
	**Weakness:** The statewide average rate fell below the minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure for the second year in a row. **Recommendations:** HSAG recommends that the plan conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services.

Dental Plans

Strengths	
	Two statewide average rates, *Follow-Up after Emergency Department Visits for Dental Caries in Children—7-Day Follow-Up—Total (0–20 Years)* and *Follow-Up After Emergency Department Visits for Dental Caries in Children—30-Day Follow-Up Total (0–20 Years)* improved by more than 3 percentage points in MY 2022 relative to MY 2021. The results suggest that plans are implementing strategies for children to receive follow-up care after an ED visit for dental caries within the 7- and 30-day time frame. Performing follow-up services helps identify and prevent progression of decay.

Weaknesses and Recommendations	
	**Weakness:** Two statewide average rates, *Topical Fluoride for Children—Dental or Oral Health Services—Total (1–20 Years)* and *Follow-Up After Dental-Related Emergency Department Visits—Total* declined by more than 3 percentage points in MY 2022 relative to MY 2021. **Recommendations:** HSAG recommends that the health plans conduct an analysis of SDOH to identify any disparities preventing members from receiving dental treatment services. Upon identification of any health disparities in the plans' populations, HSAG recommends that the health plans implement appropriate interventions to access to care. If barriers to care are impacting the rates, the plans should also evaluate their networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends offering extended office hours/weekend availability or mobile clinics for members who may have barriers such as work or transportation.
	Weakness: All dental plans fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator. **Recommendations:** HSAG recommends that the plans conduct an analysis of SDOH to identify any disparities preventing members from receiving dental treatment services. Upon identification of any disparities in the plans' populations, HSAG recommends that the plans implement appropriate interventions to access to care. If barriers to care are impacting the rates, HSAG recommends that the plans also evaluate their networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends that the plans work with providers to offer extended office hours/weekend availability or mobile clinics for members who may have barriers such as work or transportation.

Performance Improvement Projects

Introduction

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving plan processes is expected to have a favorable effect on health outcomes and member satisfaction. Information about the methods of validation used by the EQRO are included in Appendix B.

PIP Validation

For SFY 2022–2023, most plans submitted two PIPs for annual validation—Administration of the Transportation Benefit and Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. Children's Medical Services-S also submitted the Reducing Asthma Related PPEs for Pediatric Enrollees PIP and the Youth Transitions to Adult Care PIP for annual validation. Each dental plan also submitted two PIPs for annual validation—Coordination of Transportation Services With the SMMC Plans and Preventive Dental Services for Children.

This section presents the results of the PIP validation activities conducted by HSAG during SFY 2022–2023.

High-Level Review

The Agency also contracts with HSAG to conduct high-level reviews of state-mandated PIPs. A high-level review consists of reviewing the PIP documentation for alignment with the Agency-defined specifications, assessing the accuracy of data, and assessing the quality of improvement strategies and interventions deployed by the plan. HSAG provided written feedback directly into the PIP Submission Form and did not produce a validation tool.

Most plans submitted two PIPs—Improving Birth Outcomes and Reducing PPEs—for high-level review. The only exceptions were Florida Community Care-L, an LTC Plus plan, and Children's Medical Services-S, a specialty plan. The Improving Birth Outcomes PIP was not initiated by Florida Community Care-L and Children's Medical Services-S because the topic was not applicable to the population served by these plans. Children's Medical Services-S did not initiate the statewide Reducing PPEs PIP; however, the plan conducted the Reducing Asthma Related PPEs for Pediatric Enrollees PIP.

For high-level review, each dental plan submitted the Reducing Potentially Preventable Dental-Related Emergency Department Visits PIP. Additional information and results of the high-level review process are included in Appendix D.

Plan Names and Enrollment

Some tables in this section include abbreviated names of plans. Full plan names can be found in Appendix A. In addition, plan-specific enrollment should be noted when interpreting results.

Status of PIP Topics

In a PIP, the plans are required to have a baseline measurement period to determine the baseline performance indicator rate and at least two remeasurement periods to measure and assess achievement of improvement in the performance indicator rates over the baseline performance. The plans should determine the PIP measurement periods during the PIP Design stage. The measurement periods should be selected based on the availability of data at the time of the PIP submission, and if the PIP performance indicators are based on nationally recognized measures, the plans may choose the measurement periods in alignment with the measurement periods defined for the nationally recognized measures. For example, the performance indicator for the Preventive Dental Services for Children PIP is based on the CMS-416 measure and has federal fiscal year (FFY)-based measurement periods. The HEDIS-based performance indicators in the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP have CY-based measurement periods.

Table 4-1 displays the PIP topics, type of review conducted, progression status, and the measurement periods for the PIPs during SFY 2022–2023. The topics addressed CMS requirements related to quality outcomes, specifically the quality of, timeliness of, and access to care and services.

Table 4-1—PIP Topics and Status

PIP Topic	Review Type	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in SFY 2022–2023
Improving Birth Outcomes	High-Level Review	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2016	10/01/20–09/30/21 (Remeasurement 3)
Reducing PPEs	High-Level Review	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	SFY 2015–2016	10/01/20–09/30/21 (Remeasurement 3)
Administration of the Transportation Benefit	Validation	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2018 for health plans operating throughout 2018; CY 2019 for new health plans*	CY 2021 (Remeasurement 2/ Remeasurement 3)
Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	Validation	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2019	CY 2021 (Remeasurement 1)
Reducing Potentially Preventable Dental–Related Emergency Department Visits	High-Level Review	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	SFY 2016–2017	10/01/20–09/30/21 (Remeasurement 1)
Coordination of Transportation Services	Validation	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2019*	CY 2021 (Remeasurement 2)
Preventive Dental Services for Children	Validation	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	FFY 2019	FFY 2022 (Remeasurement 3)

* Four plans reported CY 2018 as the baseline.

Plans and PIP Topics

In Florida, 18 plans serving the Medicaid population (six comprehensive plans, three MMA plans, five specialty plans, one LTC plan, and three dental plans) participated in PIPs. Although 18 plans serve Florida's Medicaid population, the Agency did not require its comprehensive plans to submit separate PIPs for their specialty plans. However, some of the comprehensive plans did report separate performance indicator rates for their specialty populations for certain PIPs. Table 4-2 shows the comprehensive plans, with their associated specialty plan (when applicable) and the PIP topics conducted.

Table 4-2—Comprehensive and MMA Plans and PIP Topics

Plan	Inclusion of Specialty Plan in PIP	PIP Topics
Comprehensive Plans		
Aetna-C	None.	**For Validation** • Administration of the Transportation Benefit • Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence **For High-Level Review** • Improving Birth Outcomes • Reducing PPEs
Humana-C	None.	
Molina-C	Included Molina-S in comprehensive plan PIPs; reported separate rates for Molina-S for all PIPs.	
Simply-C	Included Clear Health-S in comprehensive plan PIPs; reported separate rates for Clear Health-S for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP and high-level review PIPs.	
Sunshine-C	Included Sunshine-S-CW and Sunshine-S-SMI in comprehensive plan PIPs; reported separate rates for Sunshine-S-CW for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP and high-level review PIPs.	
United-C	None.	
MMA Plans		
AmeriHealth-M*	No.	**For Validation** • Administration of the Transportation Benefit • Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People
Vivida-M**	No.	
Community Care Plan-M	No.	

Plan	Inclusion of Specialty Plan in PIP	PIP Topics
		With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence **For High-Level Review** • Improving Birth Outcomes • Reducing PPEs

[*] On 8/24/2021, Florida True Health/Prestige Health Choice's name changed to AmeriHealth Caritas Florida, Inc.
** Vivida Health was acquired by Simply-C on 11/1/2022 but still reported their PIP results.

Table 4-3 shows the specialty and LTC plans, indicates if a specialty plan's population was included by its operating comprehensive plan (when applicable), and the PIP topics conducted by each plan.

Table 4-3—Specialty and LTC Plans and PIP Topics

Plan	Included in Comprehensive Plan PIP	PIP Topics
Specialty Plans		
Children's Medical Services-S	No.	**For Validation** • Administration of the Transportation Benefit • Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence Youth Transitions to Adult Care • Reducing Asthma Related PPEs for Pediatric Enrollees
Clear Health-S	Yes; A specialty plan operated by Simply-C.	N/A
Molina-S	Yes; A specialty plan operated by Molina-C.	N/A
Sunshine-S-CW	Yes; A specialty plan operated by Sunshine-C.	N/A
Sunshine-S-SMI	Yes; A specialty plan operated by Sunshine-C.	N/A

Plan	Included in Comprehensive Plan PIP	PIP Topics
LTC Plan		
Florida Community Care-L	No.	**For Validation** • Administration of the Transportation Benefit • Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence **For High-Level Review** • *Reducing PPEs*

All three dental plans were required to conduct three PIPs, as shown in Table 4-4.

Table 4-4—Dental Plans Included in PIP Results

Dental Plan	PIP Topics
DentaQuest-D	**For Validation** • Coordination of Transportation Services With the SMMC Plans • Preventive Dental Services for Children **For High-Level Review** • Reducing Potentially Preventable Dental-Related Emergency Department Visits
Liberty-D	
MCNA-D	

Domains of Care

Table 4-5 lists all PIP topics and the assigned domains of care (quality, timeliness, and/or access to care).

Table 4-5—PIP Topics—Domains of Care

PIP Name	Quality	Timeliness	Access
Administration of the Transportation Benefit		✓	✓
Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	✓	✓	✓
Improving Birth Outcomes	✓	✓	✓
Reducing PPEs	✓	✓	✓
Reducing Potentially Preventable Dental-Related Emergency Department Visits	✓	✓	✓
Coordination of Transportation Services With the SMMC Plans		✓	✓
Preventive Dental Services for Children	✓	✓	✓
Youth Transitions to Adult Care	✓	✓	✓
Reducing Asthma Related PPEs for Pediatric Enrollees	✓	✓	✓

Validation Status

HSAG validated the submitted PIPs conducted during the preceding 12 months period, 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 align with the three PIP stages—Design, Implementation, and Outcomes—and the steps in CMS' EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS Protocol 1).[4-1] HSAG designated some evaluation elements as critical because of their importance in defining a project as valid and reliable.

HSAG validated the Administration of the Transportation Benefit PIP and the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP for 10 plans (six comprehensive plans, two MMA plans, one LTC plan, and Children's Medical Services-S). These PIPs were not applicable to the three dental plans, and four specialty plans were included in the

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 1, 2024.

PIP conducted by their operating comprehensive plan. All PIPs validated in SFY 2022–2023 had progressed to reporting to the Outcomes stage (Steps 1 through 9). All the plans were assessed for achievement of significant improvement in PIP outcomes during the remeasurement period.

Children's Medical Services-S reported Remeasurement 2 (CY 2021) results for the Youth Transitions to Adult Care and Reducing Asthma Related PPEs for Pediatric Enrollees PIPs.

All three dental plans reported remeasurement data for both dental PIPs that were validated.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each plan's PIP Submission Form. Each plan completed the form for PIP activities conducted during the MY and submitted it to HSAG for validation. The PIP Submission Form presents instructions for documenting information related to each of the steps in CMS Protocol 1. The plans could also attach relevant supporting documentation with the PIP Submission Form.

For the Administration of the Transportation Benefit PIP, the plans used the Agency-provided specifications to calculate the performance indicator rates. The data were obtained from the monthly reports submitted by the transportation vendors to the plans.

For the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP and the Youth Transitions to Adult Care and Reducing Asthma Related PPEs for Pediatric Enrollees PIPs, the plans used claims and encounters data to calculate the indicator rates for the selected PIP topic.

The dental plans used the Agency-provided specifications for the Coordination of Transportation Services With the SMMC Plans PIP and CMS Child Core Set Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH) measure specifications for the Preventive Dental Services for Children PIP. Administrative data, including telephone/call center data, case management reports, and/or transportation referral reports, were used to calculate rates for the Coordination of Transportation Services With the SMMC Plans PIP. For the Preventive Dental Services for Children PIP, claims/encounters data were used.

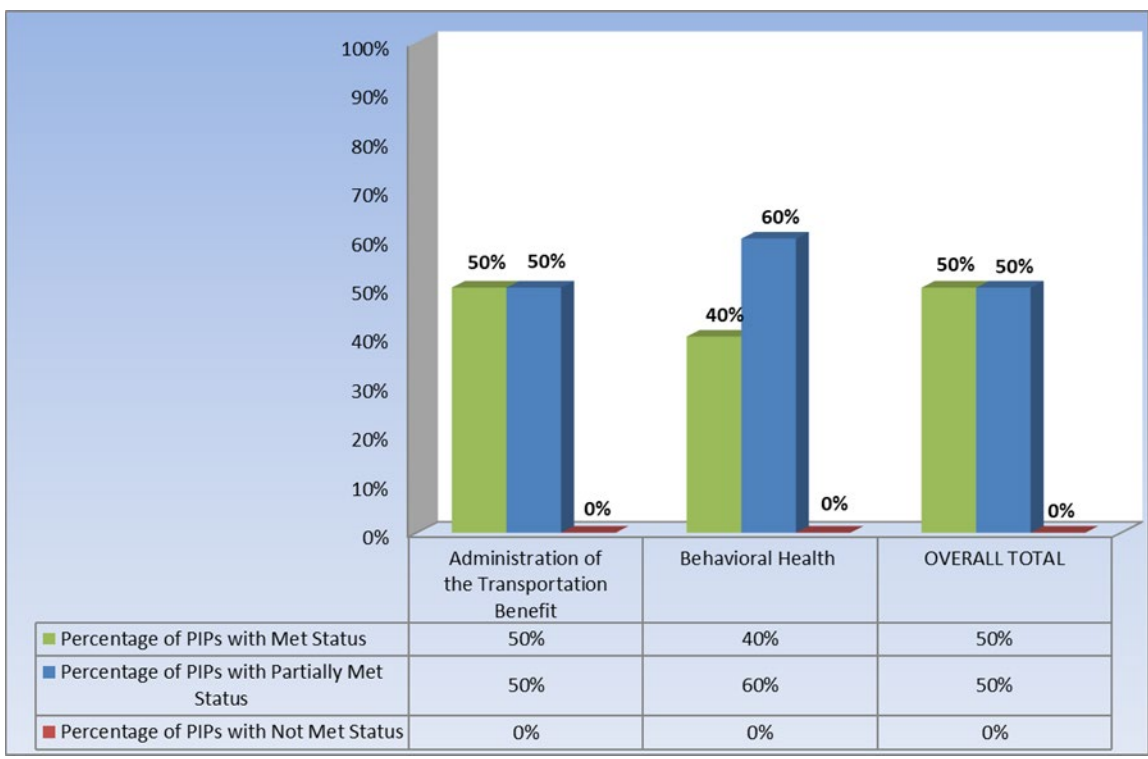
Plan PIP Validation Results

Administration of the Transportation Benefit and Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP

Overall PIP Validation Status

Figure 4-1 displays the percentage of plan PIPs receiving a *Met, Partially Met,* and *Not Met* overall validation status by PIP topic. A total of 10 plans submitted 22 PIPs for validation. The green bars represent the percentage of PIPs with an overall *Met* validation status, 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 4-1— SFY 2022-2023 Validation Status of Plan PIPs by PIP Topic



	Administration of the Transportation Benefit	Behavioral Health	OVERALL TOTAL
Percentage of PIPs with Met Status	50%	40%	50%
Percentage of PIPs with Partially Met Status	50%	60%	50%
Percentage of PIPs with Not Met Status	0%	0%	0%

Overall, 50 percent (11/22) of PIPs received a Met validation status. For the Administration of the Transportation Benefit PIP, five PIPs received a Partially Met validation status, and for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP, six PIPs received a Partially Met validation status. For both PIPs, there were

opportunities for improvement in the documentation of the statistical analysis of results, evaluation results of the interventions, and achievement of improvement in PIP outcomes. In addition to the Administration of the Transportation Benefit and the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIPs, the two additional PIPs initiated by Children's Medical Services-S were included in the overall total score, and both PIPs received a Met validation status.

Plan-Specific Results

Table 4-6 depicts the plan-specific validation results for the plan PIPs. For SFY 2022–2023, five of the 10 health plans received an overall Met validation status for the Administration of the Transportation Benefit PIP and four of the 10 health plans had an overall Met validation status for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. For both PIPs, opportunities for improvement were noted in the documentation of the statistical testing results, intervention evaluation data, and achievement of significant improvement in PIP outcomes.

Table 4-6—Plan-Specific PIP Validation Results

Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
AmeriHealth-M	Administration of the Transportation Benefit	*Partially Met*	89%	85%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Partially Met*	89%	79%
Aetna-C	Administration of the Transportation Benefit	*Partially Met*	89%	89%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Partially Met*	89%	84%

Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
Children's Medical Services-S	Administration of the Transportation Benefit	*Met*	100%	95%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Met*	100%	95%
	Youth Transitions to Adult Care	*Met*	100%	95%
	Reducing Asthma Related PPEs for Pediatric Enrollees	*Met*	100%	100%
Community Care Plan-M	Administration of the Transportation Benefit	*Partially Met*	89%	89%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Partially Met*	89%	89%
Florida Community Care-L	Administration of the Transportation Benefit	*Met*	100%	89%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Met*	100%	100%
Humana-C	Administration of the Transportation Benefit	*Met*	100%	100%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Met*	100%	95%

Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
Molina-C	Administration of the Transportation Benefit	*Partially Met*	78%	83%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Partially Met*	78%	79%
Simply-C	Administration of the Transportation Benefit	*Partially Met*	89%	95%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Partially Met*	89%	95%
Sunshine-C	Administration of the Transportation Benefit	*Met*	100%	100%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Met*	100%	95%
United-C	Administration of the Transportation Benefit	*Met*	100%	95%
	Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence	*Partially Met*	89%	84%

Comparative Performance Indicator Results and PIP Outcomes

For the Administration of the Transportation Benefit PIP, most plans reported CY 2021 data as the Remeasurement 2 data for the PIP performance indicator(s). Only three plans (Community Care Plan-M, AmeriHealth-M, and United-C) reported CY 2021 data as Remeasurement 3 rates and Aetna Better Health-C reported CY 2021 data as Remeasurement 1 data. The PIP performance indicator rates as reported by the plans are identified in Table 4-7. Six plans reported a CY 2021 rate at or above the goal of 90 percent. Four plans reported achievement of statistically significant improvement over the baseline during CY 2021. The data in green font represent statistically significant improvement over the baseline, and the green background color represents the most recent measurement period data when statistically significant improvement was achieved.

Table 4-7—Comparative Performance Indicator Remeasurement Results for the Administration of the Transportation Benefit PIP

Plan Name	Measurement Period~	Performance Indicator Rate*
Aetna Better Health-C^	Baseline CY 2020	88.4%
	Remeasurement 1 CY 2021	89.3%
AmeriHealth-M^^	Baseline CY 2018	94.1%
	Remeasurement 1 CY 2019	97.1%
	Remeasurement 2 CY 2020	89.1%
	Remeasurement 3 CY 2021	92.4%
Children's Medical Services-S	Baseline CY 2019	90.0%
	Remeasurement 1 CY 2020	94.9%
	Remeasurement 2 CY 2021	87.8%
Community Care Plan-M	Baseline CY 2018	81.4%
	Remeasurement 1 CY 2019	90.1%
	Remeasurement 2 CY 2020	92.7%
	Remeasurement 3 CY 2021	87.8%
Florida Community Care-L	Baseline CY 2019	93.13%
	Remeasurement 1 CY 2020	93.34%
	Remeasurement 2 CY 2021	90.9%
Humana-C	Baseline CY 2019	85.1%
	Remeasurement 1 CY 2020	89.7%
	Remeasurement 2 CY 2021	89.7%

Plan Name		Measurement Period~	Performance Indicator Rate*
Molina^^	Molina-C	Baseline CY 2019	97.8%
		Remeasurement 1CY 2020	95.9%
		Remeasurement 2 CY 2021	97.2%
	Molina-S	Baseline CY 2019	96.1%
		Remeasurement 1 CY 2020	95.6%
		Remeasurement 2 CY 2021	92.8%
Simply-C		Baseline CY 2019	89.5%
		Remeasurement 1 CY 2020	92.0%
		Remeasurement 2 CY 2021	93.0%
Sunshine-C		Baseline CY 2019	88.5%
		Remeasurement 1 CY 2020	88.2%
		Remeasurement 2 CY 2021	91.1%
United-C		Baseline CY 2018	93.3%
		Remeasurement 1 CY 2019	95.0%
		Remeasurement 2 CY 2020	86.4%
		Remeasurement 3 CY 2021	87.6%

~ Three plans reported CY 2018 as the baseline. Aetna-C reported CY 2020 as the new baseline measurement because the plan was able to collect only December 2019 data for CY 2019.

^^ Molina-C reported data by line of business for the comprehensive and specialty populations.

* Performance Indicator: The percentage of scheduled Leg A trip requests that resulted in the enrollee arriving to his or her scheduled appointment on time during the measurement period.

The data in green font represent statistically significant improvement over the baseline, and the green background color represents the most recent measurement period data when statistically significant improvement was achieved.

Figure 4-2 depicts the number of plans that reported achievement of statistically significant improvement, significant clinical improvement, and significant programmatic improvement. Not all the health plans reported achievement of clinical and programmatic improvement because this is optional reporting and is not required to be documented in the PIP Submission Form.

Figure 4-2—Significant Improvement Reported By Plans For SFY 2022-2023 Administration of Transportation Benefit PIP

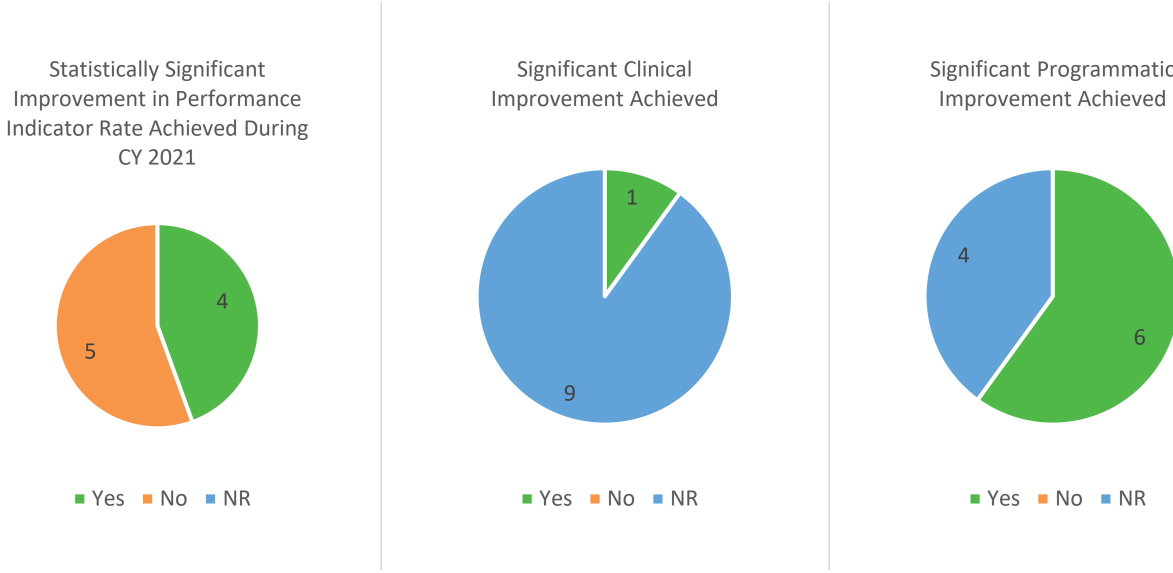


Table 4-8 displays the reported plan-specific PIP outcomes for the Administration of the Transportation Benefit PIP.

Table 4-8—PIP Outcomes for the Administration of the Transportation Benefit PIP

SFY 2022–2023Results		
Statistically Significant Improvement in CY 2021 Performance Indicator Rate Over the Baseline Achieved	**Significant Clinical Improvement Achieved**	**Significant Programmatic Improvement Achieved**
Aetna-C, Humana-C, Simply-C, Sunshine-C	Community Care Plan-M	AmeriHealth-M, Children's Medical Services-S, Community Care Plan-M, Molina-C, Simply-C, Sunshine-C

Four plans reported achievement of statistically significant improvement over the baseline during CY 2021, one plan reported achievement of significant clinical improvement, and six plans reported achievement of significant programmatic improvement. The plans that reported significant programmatic and clinical improvement based on the intervention evaluation results must expand the successful interventions to a wider population to achieve a significant increase in the performance indicator results.

For the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP, the plans reported CY 2021 as the Remeasurement 1 period. CY 2019 was the baseline year and CY 2020 was the Implementation year for this PIP. The performance indicator rates as reported by the plans are in Table 4-9 below. The data in green font represent statistically significant improvement over the baseline, and the green background color represents the most recent measurement period data when statistically significant improvement was achieved.

Table 4-9—Comparative Performance Indicator Rates for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP

Plan Name	Measurement Period~	7-Day FUH Rate*	7-Day FUM Rate**	7-Day FUA Rate***
Aetna Better Health-C	Baseline CY 2019	36.9%	26.5%	4.5%
	Implementation Year CY 2020	36.9%	27.7%	5.7%
	Remeasurement 1 CY 2021	35.7%	32.0%	7.1%
AmeriHealth-M	Baseline CY 2019	31.0%	25.2%	10.7%
	Implementation Year CY 2020	39.9%	25.6%	13.9%
	Remeasurement 1 CY 2021	35.3%	30.4%	10.2%
Children's Medical Services-S	Baseline CY 2019	41.9%	40.6%	2.3%
	Implementation Year CY 2020	45.7%	35.1%	0.0%
	Remeasurement 1 CY 2021	30.9%	42.8%	3.6%
Community Care Plan-M	Baseline CY 2019	36.0%	30.2%	3.1%
	Implementation Year CY 2020	31.3%	27.1%	1.9%
	Remeasurement 1 CY 2021	27.3%	27.3%	3.9%
Florida Community Care-L	Baseline CY 2019	11.9%	20.0%	0.0%
	Implementation Year CY 2020	10.4%	6.3%	12.5%
	Remeasurement 1 CY 2021	23.2%	40.0%	9.1%
Humana-C	Baseline CY 2019	36.6%	27.2%	4.4%
	Implementation Year CY 2020	34.5%	28.7%	6.0%
	Remeasurement 1 CY 2021	33.2%	32.0%	5.9%

Plan Name		Measurement Period~	7-Day FUH Rate*	7-Day FUM Rate**	7-Day FUA Rate***
Molina^	Molina-C	Baseline CY 2019	38.8%	22.6%	5.8%
		Implementation Year CY 2020	37.8%	30.0%	6.9%
		Remeasurement 1 CY 2021	33.5%	37.9%	8.9%
	Molina-S	Baseline CY 2019	20.4%	28.9%	6.0%
		Implementation Year CY 2020	23.7%	22.8%	5.5%
		Remeasurement 1 CY 2021	21.7%	31.9%	3.1%
Simply^	Simply-C	Baseline CY 2019	15.4%	33.6%	4.9%
		Implementation Year CY 2020	34.2%	37.2%	7.7%
		Remeasurement 1 CY 2021	33.8%	32.6%	6.3%
	Clear Health-S	Baseline CY 2019	8.1%	30.1%	5.3%
		Implementation Year CY 2020	14.6%	24.5%	8.2%
		Remeasurement 1 CY 2021	16.9%	21.5%	8.5%
Sunshine^	Sunshine -C	Baseline CY 2019	31.3%	25.3%	4.6%
		Implementation Year CY 2020	32.7%	21.4%	6.5%
		Remeasurement 1 CY 2021	22.9%	26.1%	5.7%
	Sunshine -S-CW	Baseline CY 2019	45.6%	52.2%	1.3%
		Implementation Year CY 2020	48.4%	57.5%	2.9%
		Remeasurement 1 CY 2021	42.6%	49.6%	2.5%
United-C		Baseline CY 2019	29.6%	25.8%	7.7%
		Implementation Year CY 2020	28.9%	23.1%	5.9%
		Remeasurement 1 CY 2021	27.0%	26.3%	5.0%

~ CY 2019 is the baseline and CY 2020 is the implementation year for this PIP. CY 2020 rates were not assessed for statistically significant improvement. CY 2021 (Remeasurement 1 period) rates in green font and green background color represent statistically significant improvement over the baseline.
* *Follow-Up After Hospitalization for Mental Illness—7-Days*
** *Follow-Up After Emergency Department Visit for Mental Illness—7-Days*
*** *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Days*
^ Data by line of business for the comprehensive and specialty populations.

Figure 4-3 depicts the number of plans that reported achievement of statistically significant improvement, significant clinical improvement, and significant programmatic improvement in the SFY 2022–2023 submission.

Figure 4-3—Significant Improvement Reported by Plans For SFY 2022–2023 Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP

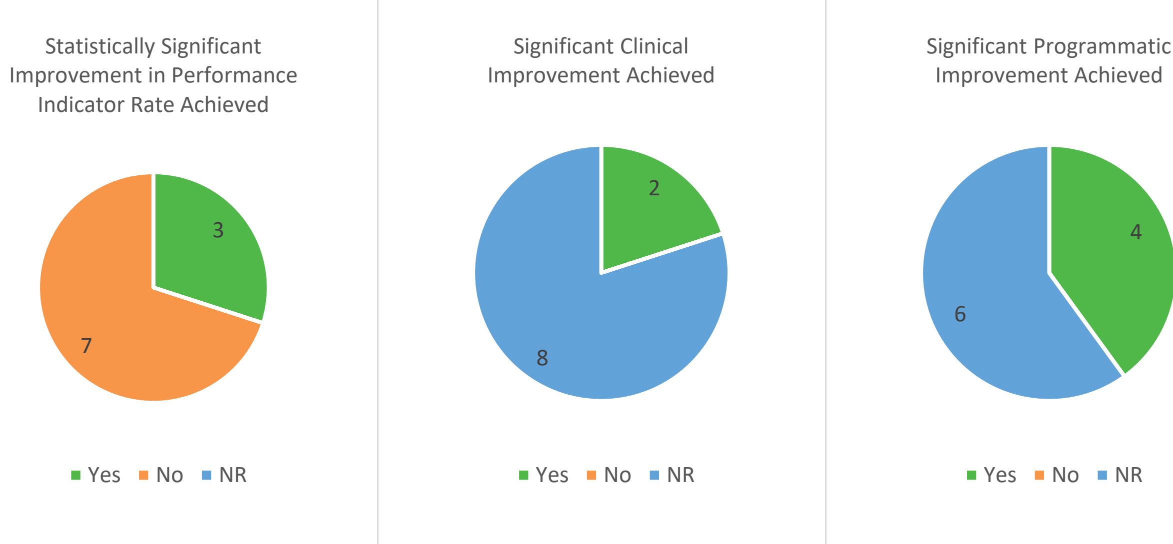


Table 4-10 displays the reported plan-specific PIP outcomes for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP.

Table 4-10—PIP Outcomes for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP

SFY 2022–2023 Results		
Statistically Significant Improvement in CY 2021 Performance Indicator Rate Over the Baseline Achieved	**Significant Clinical Improvement Achieved**	**Significant Programmatic Improvement Achieved**
Humana-C, Molina-C, Simply-C	Community Care Plan-M, Simply-C	Community Care Plan-M, Florida Community Care-L, Simply-C

Only three plans reported achievement of statistically significant improvement over the baseline during CY 2021; however, the improvement was achieved in only one of the three performance indicators. Humana-C and Molina-C documented improvement in the *FUM* measure rate, and Simply-C documented improvement in the *FUH* measure rate for both its comprehensive and specialty (ClearHealth-S) population. Two plans reported achievement of significant clinical improvement, and three plans reported achievement of significant programmatic improvement.

Plan Improvement Strategies

A plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions employed by the plans for appropriateness to the barriers identified, and timeliness of the implementation of the interventions. Table 4-11 displays the interventions as documented by the plans for the Administration of the Transportation Benefit PIP, and Table 4-12 displays the interventions for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP.

Table 4-11—Interventions Implemented/Planned for the Administration of the Transportation Benefit PIP

Plan Name	Interventions Implemented/Planned
Aetna-C	• Identify under-performing providers. ModivCare is using virtual assistance via Global Positioning System and Smart Tablets to track and trend Transportation Timeliness. Transportation providers that are not meeting the 90 percent goal are placed on corrective action plans (CAPs). • Identify enrollee no-shows and distribute a report identifying those enrollees quarterly. ModivCare outreach team to capture issues the enrollees encounter with the transportation provider.
AmeriHealth-M	• Transportation vendor works with identified care facilities to encourage understanding of how to appropriately schedule trips and implement more accurate form of reporting appointment timeliness. • Encourage open communication between the vendor account managers and the transportation providers. Provide real-time support.
Children's Medical Services-S	• New tracking software to track performance of the vendors. • Corrective action plans for providers (transportation vendors) not meeting targets.
Community Care Plan-M	• Health plan requires weekly updates by the transportation vendor to Account Services and monthly updates to health plan Quality Improvement Committee.
Florida Community Care-L	• FCC's call center conducts post transportation service survey. • FCC's call center will ensure that language and vehicle type needs are being captured during scheduling. • Ride2MD (transportation vendor) started using interactive voice response (IVR) reminder calls. • Provider performance is monitored during the PIP period and discussed on monthly calls. Ride2MD will reduce trip volume.
Humana-C	• Targeted on-site visits with Adult Day Care Centers that have the highest volume of LTC membership, provide their own transportation, and do not meet the 90 percent threshold. • Targeted on-site visits to provide education to Prescribed Pediatric Extended Care and Medication Management providers that have the highest volume of noncompliant trips. • ModivCare is identifying providers that are adversely influencing overall on-time arrival to enrollees' appointments and utilizing a PIP/CAP/Termination process to hold identified providers accountable.

Plan Name	Interventions Implemented/Planned
Molina-C (includes Molina-S)	• Transportation vendor provides coaching of protocols to the employees who do not abide by the Transportation Manual. • Provide enrollee education during transportation appointments scheduled by Molina representatives (i.e., educating enrollees about average wait time on return ride home). • Transportation vendor will flag and monitor transportation providers with a decrease in on-time performance. A reduction in the number of future trips and services by the providers may be done until improvement is made.
Simply-C (includes Clear Health-S)	• Identify and engage enrollees with prior transportation issues. • Develop an effective predictive modeling strategy in order to take a more proactive approach toward improving transportation timeliness.
Sunshine-C (includes Sunshine-S-CW and Sunshine-S-SMI)	• Enrollee Advocate Escalation Unit will handle real-time enrollee transportation complaints and provide additional collaboration with LogistiCare (vendor). • Use the Secret Shopper program as a random check on courtesy and completeness of the vendor's agents' call interactions with enrollees. • Conduct an "After-Ride" enrollee satisfaction survey. • Provide provider education materials and conduct training. • Provide enrollee education materials.
United-C	• Improve network capacity. Continue to monitor network capacity rates monthly. In addition to the recruitment and onboarding of new transportation providers, a volunteer driver program is being developed to focus on rural areas. • Identify underperforming providers, assess network coverage, and adjust volume down immediately. Providers with high volume trips and low performance placed in a Performance Improvement Plan or Corrective Action Plan (CAP). • Rewarding transportation providers who are performing above expectations with more standing orders. • Escalations and Monitoring—Place four specialists dedicated to recovery and active trip monitoring. Modified cancelation/no-show process to capture trips, which would potentially result in a complaint or missed trip. Implemented new online recommendation-based routing tool. Updated routing plans aimed at reducing recurring complaints. • Go-Digital Initiative implemented in 2021—Expanded text messaging communications to the entire Transportation Provider Network. Enhancements include enrollee appointment reminders, confirmation of reservation details, initiate return ride home (Leg-B), reservation cancellation, vehicle estimated time of arrival, vehicle identifying information, and enrollee opt-out option.

Table 4-12—Interventions Implemented/Planned for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP

Plan Name	Interventions Implemented/Planned
Aetna-C	• Utilizing Florida's ENS to facilitate timely outreach to the enrollee to schedule follow-up visits with eligible providers. • Outreach calls to enrollees to coordinate or verify scheduling of 7-day follow-up appointments. • BH liaisons conduct in-service trainings with the discharge planning teams and leadership at BH facilities that did not schedule the recommended 7-day follow-up appointments. During these meetings, the BH liaisons: • Educate the staff on the FUH HEDIS measure. • Identify barriers to scheduling appointments. • Discuss best practices.
AmeriHealth-M	• AmeriHealth utilization management (UM) will utilize Florida's ENS to improve AmeriHealth awareness of ED visit and hospital admission information daily in order to prompt the process and alert the AmeriHealth transition of care (TOC) coordinator to review the discharge plan and initiate and coordinate follow-up appointment. • Identify ED and inpatient providers through collected TOC information and recorded in the benefit and case management system (JIVA). Information is given to the provider network management (PNM) department for outreach by the assigned account executive with provider education about valid follow-up appointment requirements. TOC coordinator to initiate discharge and will communicate with enrollee and provider to assist with follow-up appointment. • High-risk indicators are established. Flag the enrollees with high-risk indicator(s) per case management record. • Healthy Behaviors programs to incentivize enrollees ($30) to have their BH follow-up appointment completed within seven days of discharge from an acute behavioral/mental health inpatient setting or ED. • To enhance insight of BH facilities and best practices, health plan's BH data are currently being narrowed down to obtain a more detailed view of admissions and discharges, to include BH-related diagnoses and top admitting facilities. This may help identify noncompliance more effectively. • The PNM department is focusing on all participating value-based care (VBC) providers and scheduling 30-minute meetings to discuss plan's BH services.
Children's Medical Services-S	• Utilize Florida's ENS real-time hospital admission, discharge, transfer (ADT) data to identify enrollees for outreach to schedule follow-up visits with primary care and/or BH providers. • Utilize automated system to notify the primary care manager, back-up care manager, supervisor, and BH manager about admissions and discharges from Crisis Stabilization Units.

Plan Name	Interventions Implemented/Planned
Community Care Plan-M	• Improve efforts to obtain real-time hospital admission ED visit notifications through Florida's ENS to facilitate timely outreach to the enrollee to schedule follow-up visits with primary care and BH providers. • Improve discharge planning and care transitions through weekly all department huddles and internal care management teams with a focus on BH.
Florida Community Care-L	• Care managers receive ENS notification of prior day ED and hospital discharges for their assigned enrollees, daily, directly to a dashboard in the care management platform on their desktop. Care managers are expected to complete enrollee outreach related to the notification within two business days and complete a Post-Hospitalization Assessment tool within five business days of discharge. • Upon notification of ED visit or inpatient admission, care manager will determine if enrollee has been diagnosed with or has self-reported mental illnesses, alcohol and other drug abuse, or dependencies. Care manager will reach out to the inpatient facility to assist with follow-up appointment before discharge. • Centralized BH discharge follow up by a new resource, a HEDIS registered nurse (RN) with BH experience.
Humana-C	• Improve efforts to obtain real-time hospital admission and ED visit notifications through ENS to facilitate timely outreach to the enrollee to schedule follow-up visits with primary care and BH providers. • Enhance discharge planning, care transitions, and post-discharge care coordination. • Enrollee Outreach and Provider Collaboration Strategies: Communication with providers of enrollees' discharge needs and plan within two days of admission; enrollee discharge care management, outreach, and engagement within three days of hospital discharge. • Inpatient Census to Outpatient Provider Program and Transitional Care Management. • Enhance care coordination, education, and enrollee and provider engagement post-ED visit. Enrollee care management, outreach and engagement within three days of ED visit. • Promote telehealth utilization and expansion for seven-day follow-up appointments. • Implement a provider scorecard to enhance provider (hospital) compliance and engagement with coordination of care, transitions, and scheduling of post-discharge appointments. • Pay for Performance Program offers monetary incentives to inpatient providers for meeting specified quality metrics.
Molina-C Molina-S	• Identification of additional enrollee information through internal and external tools for enrollees in the discharge, aftercare, and ENS reports. • Outreach and education to increase awareness of the availability of BH services. • Education to high utilizing hospitals and primary care physicians. • Assist with scheduling timely follow-up appointments.

Plan Name	Interventions Implemented/Planned
	• For specialty populations, the health plan will improve efforts to obtain real-time hospital admission and ED visit notifications through Florida's ENS to facilitate timely outreach to the enrollee to schedule follow-up visits. • The specialty plan care coordinator will confirm the enrollee is linked to a PCP or BH provider, assist with the scheduling of a timely follow-up appointment within seven days of discharge, schedule transportation if needed, and call the enrollee to verify compliance with the appointment. • Specialty plan teams, including health services and provider network, will improve collaboration with local hospitals to improve coordination with outpatient BH providers and provide education to ensure follow-up care occurs within seven days of discharge/ED visit.
Simply-C	• Improving ENS notifications to obtain discharge information and accurate contact information for effective follow-up care. • Plan engaged three BH providers who agreed to participate in BH Tele-initiative intervention and requested that participating providers contact every enrollee discharged from a BH hospitalization within 24 hours and provide an immediate telehealth BH visit, which will address the FUH—7 Days population. • Provide enrollees with a $25 gift card for completion of each of the 7- and 30-day follow-up appointments following an ED visit. • Data Reconciliation Project utilizing an automated process in which encounters are instantly reconciled and checked for accuracy.
Sunshine-C	• Utilize Florida's ENS real-time hospital ADT data and other data sources to identify enrollees for outreach to provide education regarding the importance and need for a follow-up appointment, to offer assistance with scheduling the appointment, to provide education regarding the option of using telehealth for the follow-up appointment, and to provide assistance with arranging transportation if an in-person appointment is preferred by the enrollee.
United-C	• Optum Chronic Care Management (CCM) program is designed to support enrollees with BH needs, including those related to mental health and substance use. • Optum virtual case health worker (CHW) team: Enrollees discharged for a low-risk BH condition are assigned a virtual CHW, who ensures enrollee has follow-up appointment within the appropriate time frame. • Daily ENS BH custom report to be used by Optum CCM and virtual CHW program. • Engaging and encouraging providers to adopt ENS. • BH care management team to begin using portal maintained by Audacious Inquiry (HIE). Portal houses enrollee contact information from the most recent ED or hospital visited by the enrollee. • Screening, Brief Intervention, and Referral to Treatment Regarding Substance Use Disorders (SBIRT) Enhanced Provider Toolkit. • Value-based Contracting (Shared Savings)—This model for outpatient providers offers a shared savings opportunity based on a reduction of inpatient costs and achievement of

Plan Name	Interventions Implemented/Planned
	one or more quality metrics (three metrics in all) including FUH. This model targets Community Mental Health Centers and large providers. • Value-based Contracting (Health Home)—This model is the Optum Behavioral National Model developed to drive total cost of care value and improved health outcomes through a managed health home model paired with a monthly case rate and potential shared savings opportunity. This model targets large outpatient providers. • Behavioral Health Provider Incentive Program offering providers an opportunity to earn bonuses by helping members become more engaged in their healthcare treatment.

Children's Medical Services-S Two Additional PIPs Validation Results

Children's Medical Services-S submitted two alternative PIPs—Youth Transitions to Adult Care and Reducing Asthma Related PPEs for Pediatric Enrollees for validation. In SFY 2022–2023, both PIPs received an overall Met validation status and achieved a 100 percent Met score for all the evaluation elements.

Performance Indicator Results

In SFY 2022–2023, Children's Medical Services-S reported finalized Remeasurement 2 (CY 2021) results for the Youth Transitions to Adult Care and Reducing Asthma Related PPEs for Pediatric Enrollees PIPs. For the Youth Transitions to Adult Care PIP, Children's Medical Services-S reported a decrease in the performance indicator rate over the baseline. The plan did not report any evidence of significant clinical or programmatic improvement. For the Reducing Asthma Related PPEs for Pediatric Enrollees PIP, Children's Medical Services-S sustained a statistically significant increase over the baseline for both performance indicators for the two consecutive remeasurement periods. The PIP performance indicators' rates as reported by Children's Medical Services-S are displayed in Table 4-13 and Table 4-14. The data in green font represent statistically significant improvement over the baseline, and the green background color represents the most recent measurement period data when statistically significant improvement was achieved.

Table 4-13—Performance Indicator Rates for the Youth Transitions to Adult Care PIP

PIP Name	Measurement Period	Performance Indicator Rate*
Youth Transitions to Adult Care	Baseline CY 2019	0.8%
	Remeasurement 1 CY 2020	1.3%
	Remeasurement 2 CY 2021	0.6%

* Performance Indicator: The percentage of enrollees 18 to 21 years of age who transitioned from a pediatric provider to an adult care provider during the measurement period.

Table 4-14—Performance Indicator Rates for the Reducing Asthma Related PPEs for Pediatric Enrollees PIP

PIP Name	Measurement Period	Performance Indicator 1 Rate*	Performance Indicator 2 Rate**
Reducing Asthma Related PPEs for Pediatric Enrollees	Baseline CY 2019	71.6%	94.2%
	Remeasurement 1 CY 2020	95.4%	99.4%
	Remeasurement 2 CY 2021	93.0%	98.2%

* Performance Indicator 1: The percentage of enrollees 5 to 18 years of age who did not have an asthma-related ED visit.

** Performance Indicator 2: The percentage of enrollees 5 to 18 years of age who did not have an asthma-related hospital admission. The data in green font represent statistically significant improvement over the baseline, and the green background color represents the most recent measurement period data when statistically significant improvement was achieved.

Table 4-15 displays the reported plan-specific PIP outcomes for the additional Children's Medical Services-S PIPs.

Table 4-15—PIP Outcomes for the Additional Children's Medical Services-S PIPs

PIP Name	SFY 2022–2023 Results		
	Statistically Significant Improvement in CY 2021 Performance Indicator Rate Over the Baseline Achieved	Significant Clinical Improvement Achieved	Significant Programmatic Improvement Achieved
Youth Transitions to Adult Care	*No*	*NR*	*NR*
Reducing Asthma Related PPEs for Pediatric Enrollees	*Yes*	*NR*	*Yes*

Children's Medical Services-S reported achievement of statistically significant improvement over the baseline and programmatic improvement in the Reducing Asthma Related PPEs for Pediatric Enrollees PIP. No improvement was achieved in the Youth Transitions to Adult Care PIP.

Performance Improvement Strategies

Table 4-16 displays the interventions as documented by Children's Medical Services-S for the two additional PIPs.

Table 4-16—Interventions for the Children's Medical Services-S PIP

PIP Name	Interventions Implemented/Planned
Youth Transitions to Adult Care	• Created transition assessment tool to guide care managers while they evaluate enrollee transition readiness or progress. • Created transition care plan template for care managers to assist enrollees with transitioning from pediatric to adult providers. • Educate enrollees regarding how to search for adult providers using the online provider search tool. • Developed a training program for care managers regarding the steps necessary to support enrollees with transitioning from pediatric to adult providers. • Develop reports to assist care managers with identifying when transition assessment and planning need to occur.
Reducing Asthma Related PPEs for Pediatric Enrollees	• Developed "Asthma Action Plan" for enrollee education. This plan is pending approval from the Department of Health. This three-step written plan for enrollees is to help them self-direct their care and know when to contact their doctor. Enrollees complete this tool with their PCP. • "My Asthma Diary" is a booklet designed to help children and parents/caregivers identify and learn to manage/avoid their asthma triggers. The booklet will be mailed to the enrollee and the care manager will follow up to provide further education. • Expanded benefits provide carpet cleaning, HEPA filter vacuum cleaner, hypoallergenic bedding, and pest control services to eligible enrollees to make their homes' environment more asthma-control friendly.

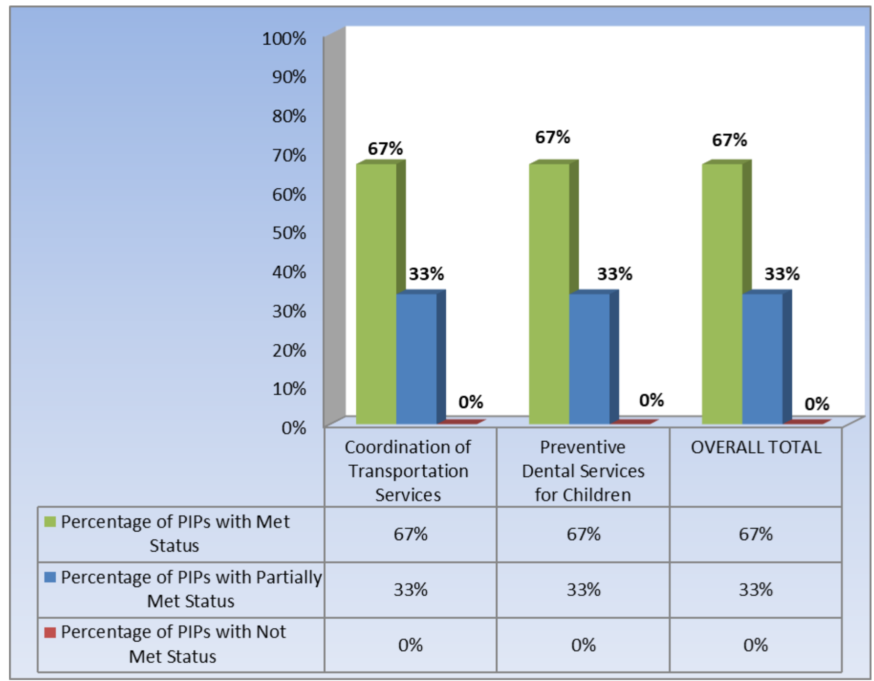
Dental Plans PIP Validation Results

A total of three dental plans submitted six PIPs for validation. Each dental plan submitted the state-mandated Coordination of Transportation Services With the SMMC Plans PIP and Preventive Dental Services for Children PIP.

Overall Validation Status

Figure 4-4 displays the percentage of dental plan PIPs receiving a *Met*, *Partially Met*, and *Not Met* overall validation status by PIP topic.

Figure 4-4—SFY 2022–2023 Overall Validation Status of Dental Plans PIPs by PIP Topic



	Coordination of Transportation Services	Preventive Dental Services for Children	OVERALL TOTAL
Percentage of PIPs with Met Status	67%	67%	67%
Percentage of PIPs with Partially Met Status	33%	33%	33%
Percentage of PIPs with Not Met Status	0%	0%	0%

Four of the six dental PIPs (67 percent) received an overall *Met* validation status. There were opportunities for improvement in the reporting of performance indicator data, narrative interpretation of data, and evaluation results of the interventions.

Dental Plan-Specific Results

Table 4-17 depicts and compares the dental plan-specific SFY 2022–2023 PIP validation results for the dental PIPs. Two of the three dental plans received an overall *Met* validation status for both PIPs. Liberty-D had opportunities for improvement in reporting accurate data and documenting complete intervention evaluation data.

Table 4-17—Dental Plan-Specific PIP Validation Results

Dental Plan Name	PIP Name	Validation Status	Percentage Score of Critical Elements Met	Percentage Score of Evaluation Elements Met
DentaQuest-D	Coordination of Transportation Services With the SMMC Plans	*Met*	100%	89%
	Preventive Dental Services for Children	*Met*	100%	100%
Liberty-D	Coordination of Transportation Services With the SMMC Plans	*Partially Met*	89%	89%
	Preventive Dental Services for Children	*Partially Met*	78%	79%
MCNA-D	Coordination of Transportation Services With the SMMC Plans	*Met*	100%	100%
	Preventive Dental Services for Children	*Met*	100%	100%

Comparative Dental Plan PIP Performance Indicator Results

For the Preventive Dental Services for Children PIP, the dental plans reported completed Remeasurement 2 (FFY 2021) rates for the PIP performance indicator. This PIP is based on the CMS416 measure which is reported as FFY. DentaQuest-D and Liberty-D achieved statistically significant improvement over the baseline; however, MCNA-D had a decline in the performance indicator rate compared to the baseline. The PIP performance indicator rates as reported by the dental plans are displayed in Table 4-18. The data in green font represent statistically significant improvement over the baseline, and the green background color represents the most recent measurement period data when statistically significant improvement was achieved.

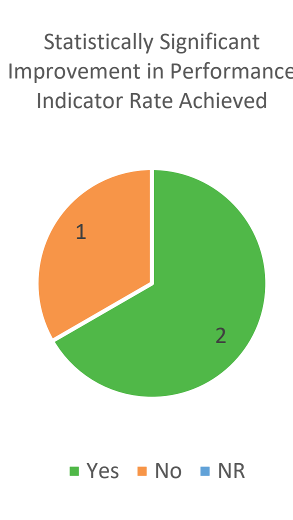
Table 4-18—Comparative Performance Indicator Rates for the Preventive Dental Services for Children PIP

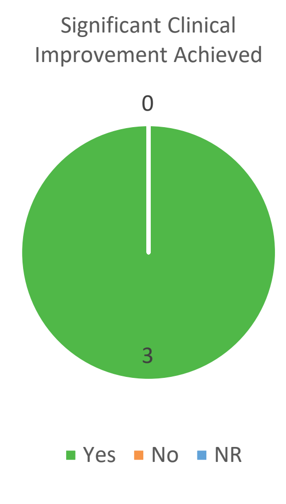
Dental Plan Name	Measurement Period*	Performance Indicator Rate**
DentaQuest-D	Baseline FFY 2019	36.3%
	Remeasurement 1 FFY 2020	32.7%
	Remeasurement 2 FFY 2021	37.1%
Liberty-D	Baseline FFY 2019	34.5%
	Remeasurement 1 FFY 2020	31.6%
	Remeasurement 2 FFY 2021	38.5%
MCNA-D	Baseline FFY 2019	36.0%
	Remeasurement 1 FFY 2020	31.1%
	Remeasurement 2 FFY 2021	32.2%

** Performance Indicator: The percentage of enrollees 1 to 20 years of age that had at least one preventive dental service during the measurement year (MY).
The data in green font and green background color represent statistically significant improvement over the baseline.

Figure 4-5 depicts the number of dental plans that reported achievement of statistically significant improvement, significant clinical improvement, and significant programmatic improvement in the SFY 2022–2023 submission.

Figure 4-5—Significant Improvement Reported by Dental Plan for SFY 2022–2023 Preventive Dental Services for Children PIP





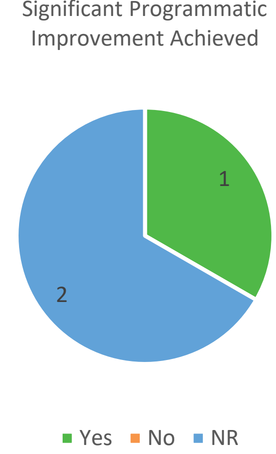


Table 4-19 displays the reported dental plan-specific PIP outcomes for the Preventive Dental Services for Children PIP.

Table 4-19—PIP Outcomes for the Preventive Dental Services for Children PIP

SFY 2022–2023 Results		
Statistically Significant Improvement in FFY 2021 Performance Indicator Rate Over the Baseline Achieved	**Significant Clinical Improvement Achieved**	**Significant Programmatic Improvement Achieved**
DentaQuest-D, Liberty-D	All three dental plans	Liberty-D

Two dental plans achieved statistically significant improvement over the baseline. All three dental plans reported achievement of significant clinical improvement, and Liberty-D also reported achievement of significant programmatic improvement.

For the Coordination of Transportation Services With the SMMC Plans PIP, the dental plans reported finalized Remeasurement 2 (CY 2021) rates for the PIP performance indicator(s). For Performance Indicator 1, Liberty-D and MCNA-D reported a baseline and Remeasurement 2 rate of 100 percent. DentaQuest-D documented a decline in the Performance Indicator 1 rate from the baseline. For Performance Indicator 2, Liberty-D achieved statistically significant improvement over the baseline; however, MCNA-D had a decline in the performance indicator rate. Due to data collection issues, DentaQuest-D reassigned CY 2021 as the new baseline for Performance Indicator 2 and was, therefore, not assessed for improvement on the Performance Indicator 2 rate. The PIP performance indicator rates as reported by the dental plans are displayed in Table 4-20. The data in green font represent statistically significant improvement over the baseline, and the green background color represents the most recent measurement period data when statistically significant improvement was achieved.

Table 4-20—Comparative Performance Indicator Rates for the Coordination of Transportation Services With the SMMC Plans PIP

Dental Plan Name	Measurement * Period	Performance Indicator 1 Rate**	Performance Indicator 2 Rate***
DentaQuest-D	Baseline CY 2019	96.3%	NR
	Remeasurement 1 CY 2020	90.5%	NR
	Remeasurement 2 CY 2021	92.2%	36.1%
Liberty-D	Baseline CY 2019	100%	9.8%
	Remeasurement 1 CY 2020	100%	23.4%
	Remeasurement 2 CY 2021	100%	28.1%

Dental Plan Name	Measurement * Period	Performance Indicator 1 Rate**	Performance Indicator 2 Rate***
MCNA-D	Baseline CY 2019	100%	62.0%
	Remeasurement 1 CY 2020	100%	54.6%
	Remeasurement 2 CY 2021	100%	67.7%

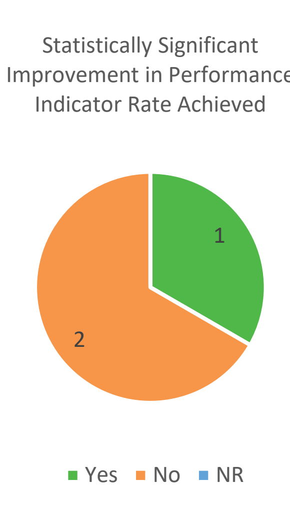
* Due to data collection issues, DentaQuest-D reassigned CY 2021 as the new baseline for Performance Indicator 2.

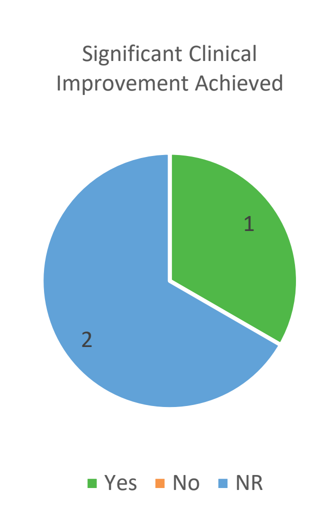
** Performance Indicator 1: The percentage of requests for transportation to and/or from covered oral health services that the dental plan referred to and/or scheduled with the enrollee's SMMC plan or the enrollee's SMMC plan's transportation vendor.

*** Performance Indicator 2: The percentage of requests for transportation to and/or from covered oral health services that the dental plan referred to and/or scheduled with the enrollee's SMMC plan and/or the enrollee's SMMC plan's transportation vendor AND where the dental plan contacted the enrollee to ensure that the transportation was scheduled, and the enrollee had been notified.

Figure 4-6 depicts the number of dental plans that reported achievement of statistically significant improvement, significant clinical improvement, and significant programmatic improvement in the SFY 2022–2023 submission.

Figure 4-6—Significant Improvement Reported by Dental Plan for SFY 2022–2023 Coordination of Transportation Services PIP





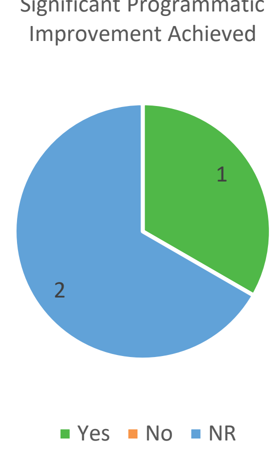


Table 4-21 displays the reported dental plan-specific PIP outcomes for the Coordination of Transportation Services PIP. Liberty-D reported achievement of statistically significant improvement over the baseline and significant programmatic improvement, MCNA-D reported achievement of significant clinical improvement, and DentaQuest-D did not achieve any significant improvement.

Table 4-21—PIP Outcomes for the Coordination of Transportation Services With the SMMC Plans PIP

SFY 2022–2023 Results		
Statistically Significant Improvement in CY 2021 Performance Indicator Rate Over the Baseline Achieved	**Significant Clinical Improvement Achieved**	**Significant Programmatic Improvement Achieved**
Liberty-D	MCNA-D	Liberty-D

Dental Plan Improvement Strategies

Table 4-22 displays the interventions as documented by the dental plans for the Preventive Dental Services for Children PIP, and Table 4-23 displays the interventions for the Coordination of Transportation Services With the SMMC Plans PIP.

Table 4-22—Interventions Implemented/Planned for the Preventive Dental Services for Children PIP

Dental Plan Name	Interventions Implemented/Planned
DentaQuest-D	• Healthy Behavior Program to encourage enrollees to receive preventive treatment; also offering a $20 Walmart gift card to enrollees receiving preventive dental care within 180 days of enrollment. • Reimbursement fee increased for teledentistry and preventive dentistry codes. • Educational IVR call to noncompliant enrollees on importance of regular preventive care.
Liberty-D	• 1st Tooth, 1st Birthday campaign, which includes outreach to parents/guardians and providers to promote awareness of the American Academy of Pediatric Dentistry's recommendation to "Get it Done in Year One." • Enrollee incentive programs to motivate enrollees to seek preventive dental care. • A tiered payment incentive for primary dental providers. • Text message outreach campaign to target non-utilizers of preventive care.
MCNA-D	• Care Gap Alerts—MSRs offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac system during inbound calls that indicates the enrollee is overdue for a preventive dental visit. • Preventive Service Reminders—Text messages will be sent once a month to enrollees who have no claims history on file for preventive services. Enrollees will continue to receive a text message until an encounter is received. • Targeted PR Outreach for Treatment Services—Targeted PR visits to dentists who, based on dental record review, have not completed documented treatment needs.

Dental Plan Name	Interventions Implemented/Planned
	• DentalLink—Targeted prescription pad for care provided by high volume pediatric medical providers. • Practice Site Performance Summary—Quarterly provider profiling report that shows providers how they are performing against their peers. Providers will receive quarterly results to show improvement on their panel. • Provider Portal Preventive Service Gaps—Real-time preventive dental service gaps visible to providers at the time of eligibility verification in MCNA-D's Provider Portal.

Table 4-23—Interventions Implemented/Planned for the Coordination of Transportation Services With the SMMC Plans PIP

Dental Plan Name	Interventions Implemented/Planned
DentaQuest-D	• Created and distributed an informational sheet on DentaQuest-D contact information to SMMC dental health plan liaisons. • Training the member service representatives (MSRs) on enrollee assistance with the transportation requests and the tracking and reporting of enrollee transportation requests. Developed additional training for MSRs on including adequate details about enrollee transportation requests. • Enrollees who inquire about transportation are contacted via an IVR call to ensure that transportation was scheduled. Calls will take place the following month after the enrollees request transportation information from DentaQuest-D.
Liberty-D	• Liberty-D CSR and care management (CM) teams conduct live outreach to non-utilizing enrollees to inform them of transportation availability as well as appointment coordination. Additionally, CSR and CM teams also follow up about transportation inquiries, previously scheduled appointments, or any access-related barriers that may have been previously identified.
MCNA-D	• Inbound Education and Assistance—MSRs and case management educate and assist enrollees with scheduling transportation to their dental appointments through inbound calls. • Provider Portal Banner—Eligibility screen in the provider portal that reminds providers that enrollees can receive transportation assistance. • Enrollee Outreach for Missed Appointments—Collaborate with Community Care Plan-M for monthly data exchange of enrollees who miss more than two scheduled transportation trips to a dental appointment.

Conclusions and Recommendations Related to Quality, Timeliness, and Access

Program-level strengths, weaknesses, and recommendations related to quality, timeliness, and access are presented below. For plan-specific conclusions and recommendations, please see Appendix C.

Strengths	
+	The PIPs were methodologically sound. Most data reported in the PIPs appeared accurate.
+	The implemented targeted interventions were linked to the identified barriers and actively engage the enrollees or providers to improve access to, quality of, and timeliness of care.
+	For the Administration of the Transportation Benefit PIP, six out of 10 plans reported a CY 2021 rate at or above the goal of 90 percent.
+	For the Preventive Dental Services for Children PIP, two out of three dental plans achieved statistically significant improvement over the baseline, and all dental plans reported achievement of significant clinical improvement.
Weaknesses and Recommendations	
−	**Weakness:** For the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP, three health plans reported achievement of statistically significant improvement over the baseline during CY 2021; however, the improvement was achieved in only one of the three performance indicators. **Recommendations**: For the PIPs with unsuccessful outcomes, the plans must revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, the plans should ensure that data-driven decisions are made to revise the interventions in an effort to realize improvement. The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care.
−	**Weakness:** For the Coordination of Transportation Services PIP, only one dental plan achieved statistically significant improvement over the baseline. **Recommendations**: For the PIPs with unsuccessful outcomes, the plans must revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, the plans should ensure that data-driven decisions are made to revise the interventions in an effort to realize improvement. The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

	Weaknesses and Recommendations
⊖	**Weakness:** Not all plans reported complete intervention evaluation data for the PIPs. The plans included intervention evaluation data for CY 2021; however, with a submission date of October 2022, the plans should have included intervention evaluation data for CY 2022 to date. **Recommendations**: The plans must report complete intervention evaluation data as part of their PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission. Quantitative intervention evaluation data collection is preferred. Achievement of significant programmatic and significant clinical improvement must be supported by appropriate intervention evaluation data demonstrating intervention effectiveness.
⊖	**Weakness:** There were errors in the statistical testing results comparing remeasurement data to the baseline. **Recommendations**: The PIP/QI team should include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions.
⊖	**Weakness:** After the interventions were deemed successful through small-scale testing, some plans did not expand the interventions to a large enough population to impact the performance indicator for the PIP. **Recommendations**: The interventions deemed successful when tested on a small scale using Plan-Do-Study-Act (PDSA) cycles should be expanded to the entire eligible population to realize significant improvement in performance indicator rates.

Optional Activities

Introduction

EQR-related activities are the mandatory and optional activities, as set forth in 42 CFR §438.358, which produce the data and information that the EQRO analyzes when performing the EQR. EQR-related activities are intended to improve states' ability to oversee and manage the plans they contract with for services and help improve their performance with respect to the quality of, timeliness, of and access to care. In addition to the mandatory sections described in the prior sections of this report, CMS designates six optional activities. The state has discretion to determine which optional EQR-related activities, if any, it wishes to conduct and include in the annual EQR. In SFY 2022–2023, the Agency contracted HSAG to conduct the optional activities described in this section.

Encounter Data Validation (EDV)

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship. Federal regulations at 42 CFR Part 438 include several provisions related to encounter data.

During SFY 2022–2023, the Agency continued to contract with HSAG to conduct an EDV study. The goal of the SFY 2022–2023 EDV study was to examine the extent to which the LTC encounters submitted to the Agency by its contracted Comprehensive and LTC plans were complete and accurate.

In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity, October 2019,*[5-1] HSAG conducted the following core evaluation activities for the EDV activity:

Comparative analysis—Analysis of the Agency's electronic encounter data completeness and accuracy through a comparison between the Agency's electronic encounter data and the data extracted from the plans' data systems. The comparative analysis of the encounter data involved a series of analyses divided into two analytic sections:

1. HSAG assessed **record-level data completeness** using the following metrics for each LTC encounter type:
   - *Record omission*—The number and percentage of records present in the files submitted by the plans that were not found in the files submitted by the Agency.
   - *Record surplus*—The number and percentage of records present in the files submitted by the Agency but not found in the files submitted by the plans.
2. Based on the number of records present in both data sources, HSAG examined **data element-level completeness and accuracy** for key data elements based on the following metrics:
   - *Element omission*—The number and percentage of records with values present in the files submitted by the plans but not present in the files submitted by the Agency.
   - *Element surplus*—The number and percentage of records with values present in the files submitted by the Agency but not present in the files submitted by the plans.
   - *Element accuracy*—The number and percentage of records with exactly the same values in both the Agency's and the plans' submitted files.
   - *All-Element accuracy*—The number and percentage of records present in both data sources with exactly the same values for select data elements relevant to each encounter data type.

LTC service record and plan of care (POC) review—Analysis of the Agency's electronic encounter data completeness and accuracy by comparing the Agency's electronic encounter data to the information documented in the corresponding enrollees' LTC service records and POCs.

1. HSAG reviewed and analyzed the exported information collected from the developed electronic tool. HSAG used four study indicators of data completeness and accuracy to report the record review results:
   - *Record/documentation omission rate*—The percentage of sampled dates of service, diagnosis codes, procedure codes, and procedure code modifiers identified in the electronic encounter data that are not found in the enrollees' LTC service records.

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 1, 2024. Please note that CMS updated the October 2019 EQR protocols in 2023, and the new protocols were published in February 2023. HSAG developed the EDV methodology and began conducting the activities while the October 2019 protocols were in effect. As such, HSAG referenced the previously published protocols since that version was current at the time of the study development.

- *Encounter data omission rate*—The percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the enrollees' LTC service records that are not found in the electronic encounter data.
- *Accuracy rate of coding*—The percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that are correctly coded based on the enrollees' LTC service records.
- *Overall accuracy rate*—The percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

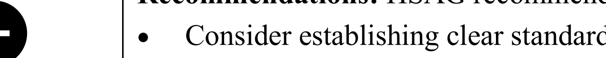
2. HSAG evaluated whether the LTC services reported in the encounters were supported by enrollees' POCs. HSAG also reviewed POC documentation for alignment with authorization dates, scheduled services, units of service, and service providers.

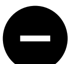
Strengths, Opportunities for Improvement, and Recommendations

Program-level strengths, weaknesses, and recommendations related to quality, timeliness, and access are presented below. For plan-specific conclusions and recommendations, please see Appendix C.

Strengths	
+	The comparative analysis results for the LTC professional encounters indicated a high degree of record completeness, with low record omission and surplus rates.
+	For encounters that could be matched between data extracted from the Agency's data warehouse and data extracted from the plans' data systems, a high degree of completeness was observed at the element level across both the LTC institutional and LTC professional encounters (i.e., low element omission and surplus rates).
+	The analysis of POC documentation indicated a high overall procurement rate and validity rate of the submitted documentation. Of the 1,022 dates of service identified in the encounter data for which HSAG requested plans to submit a POC, 98.7 percent (1,009 out of 1,022) were submitted with valid documentation. The quality of the POC documentation was generally high, with proper signatures, effective dates aligning with the selected dates of service, and identification of valid servicing providers.

Weaknesses and Recommendations	
−	**Weakness:** While the comparative analysis results indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and LTC institutional encounters, the results also indicated that there were key data elements with low accuracy rates. **Recommendation:** HSAG recommends that the Agency work with the specific plan(s) in resolving how the associated data element(s) should be submitted, collected, and reported.



Weaknesses and Recommendations	
	Weakness: Some plans' LTC record submissions were low or did not include complete and accurate supporting documentation. **Recommendations:** HSAG recommends that the Agency: • Consider establishing clear standards for record submission to ensure plans are more responsive in procuring requested records. • Monitor compliance with record submission standards and take appropriate measures for noncompliant plans.
	**Weakness:** When comparing the POC documentation to the enrollees' LTC records, HSAG found discrepancies in supporting data. Only 84.0 percent (769 out of 915) of the servicing provider information within the POC documents supported the provider information contained in the LTC records. Similarly, 80.1 percent (761 out of 950) of the documented procedure codes in the POC aligned with the procedure codes in the LTC records. Likewise, 80.5 percent (765 out of 950) of the units of service documented in the POC supported the units in the LTC records. Of note, most of the discrepancies in the servicing provider information, procedure codes, and units of service, when compared to the LTC records information for the associated dates of service, were attributed to LTC records not being submitted for the study. **Recommendations:** Some plans' LTC record submissions were low which affected the LTC record omission study indicators for all key data elements evaluated. As such, to ensure the plans' accountability for record procurement requirements, the Agency may consider strengthening and/or enforcing its contract requirements and oversight via the following: • Enhance contract requirements with the plans to ensure accountability for LTC record procurement, emphasizing the importance of submitting complete and accurate records. • Enforce contract language that addresses the submission of records by contracted providers, emphasizing the need for timely and responsive communication. • Encourage plans to address non-responsive providers and implement measures to ensure timely submission of LTC records for auditing and other examination.

Overall Assessment of Progress in Meeting EQRO Recommendations

Program-Level Assessment

During previous years, HSAG made recommendations in the annual reports for each of the activities that were conducted, as well as in the Annual Technical Report. Table 6-1 is a summary of the follow-up actions per activity that the Agency completed in response to HSAG's recommendations for the SFY 2021–2022 Technical Report. When statewide trends were identified, HSAG made recommendations for improvement for all plans. HSAG also made plan-specific recommendations.

Table 6-1—HSAG Recommendations with Agency Actions

HSAG Recommendation	Actions
Performance Improvement Projects	
For unsuccessful PIP interventions, HSAG recommends that the plans make data-driven decisions to revise or discontinue the current intervention and implement new interventions. • The plans should consider using QI science tools such as process mapping, failure modes and effects analysis (FMEA), or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small scale using PDSA cycles should be ramped up and adopted planwide in order to impact the entire eligible population.	The Agency responded that each year, the Agency sends its PIP feedback to the plans and directs the plans to address HSAG's recommendations and feedback in their subsequent PIP submissions. The Agency reinforces this process in its PIP Guidance Document that is provided to the plans each year as well.

<table>
<tr><th>HSAG Recommendation</th><th>Actions</th></tr>
<tr><td colspan="2">Performance Measure Validation</td></tr>
<tr><td>HSAG recommends that the plans serving the MMA program identify best practices for ensuring children receive all preventive vaccinations.</td><td>Plans identified the following actions in response to EQRO recommendations:

Created survey to obtain member feedback to better understand member-related barriers related to access to care.
Conducted live calls to parents/enrollees that had not yet completed their recommended child health check-up visits to assist with appointment scheduling and transportation.
Planned to conduct a root cause analysis or deeper analysis after the MY 2023 results were available to identify possible drivers of low performance in receiving recommended care and services.
Incorporated the measure into provider incentive payment plans. For example, provided a financial incentive of $50 for each member seen over the benchmark, with a goal of closing the gap in preventive care and motivating providers to engage in promoting members annual visits.
Implemented Patient-Centered Medical Home (PCMH) incentive program.
Educated providers on newly recommended age guidelines for immunizations such as Human Papillomavirus (HPV).
Used member incentives for HPV Series completion.
Conducted member outreach including:

Text campaigns, interactive voice response (IVR), email, social media
Back to school readiness events.
Flu season and immunization drive-ups.
Appointment scheduling assistance with PCPs.
Promoting education and access to incentives on the website benefits page and the patient portal including:

Worked with providers to host specific clinic days for pediatric vaccinations.

Promoted member utilization of a 24/7 telemedicine program through the telemedicine health applications.
Partnered with community medical provider groups to provide free shoes and backpacks to kids who came and received vaccines.
</td></tr>
</table>

HSAG Recommendation	Actions
The plans must ensure that the reported data and corresponding analysis in the submitted PIP form are accurate. The plans must communicate with the Agency and HSAG regarding the data to be included for the Improving Birth Outcomes and Reducing PPEs PIPs.	Plans identified the following actions in response to EQRO recommendations: • Trained plan QI staff in QI methodology, such as barrier analysis, root cause analysis, and the Plan-Do-Study-Act (PDSA) improvement cycle. • Completed causal barrier analysis using appropriate quality improvement tools, such as a fishbone diagram, to assist in the identification of barriers, contributing factors, and potential risks. Based on identified barriers, interventions were developed and implemented for the next re-measurement period. Subsequent re-measurement periods were established to assess the effectiveness of the interventions. • Conducted outreach to new members identified as pregnant, including additional initial telephonic outreach attempts, a member location unit, and community connectors for community visits in attempt to contact the member as early as possible to coordinate prenatal care, complete prenatal risk assessments and coordinate referral to any identified needs that could impact birth outcomes.
HSAG recommends that the plans serving the MMA Program conduct a root cause analysis or focus study to determine why members are not quitting tobacco use. Upon identification of a root cause, the plans should implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation.	Plans did not identify new initiatives implemented based on the HSAG recommendations.
HSAG recommends that the plans serving the MMA Program conduct a root cause analysis or focus study to: • Identify barriers experienced by providers in following the recommended guidelines for follow-up and monitoring of prescribed ADHD medication. • Determine why some children did not receive blood lead tests by their second birthday. Upon identification of any root causes contributing to these gaps in care, the plans should implement appropriate interventions to	Plans identified the following actions in response to EQRO recommendations: • Assisted members in scheduling appointments and eliminated barriers to attending appointments. • Implemented Patient-Centered Medical Home (PCMH) incentive Program. • Conducted member outreach. • Implemented text campaigns, interactive voice response (IVR), email, social media. • Conducted back to school readiness events. • Implemented appointment scheduling assistance with PCPs.

HSAG Recommendation	Actions
improve use of evidence-based practices specifically related to these pediatric services.	• Promoted education and access to incentives as part of the website benefits page and the patient portal. • Promoted member utilization of a 24/7 telemedicine program through telehealth applications. • Implemented pharmacy communications. • Increased education to parent/guardian to members prescribed ADHD medication and continued ADHD medication management pharmacy outreach program.
HSAG recommends that the plans serving the MMA Program consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. In addition, HSAG recommends that the plans analyze their data and consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that the plans implement appropriate interventions to improve the quality, accessibility, and timeliness of prenatal and postpartum care.	Plans identified the following actions in response to EQRO recommendations: • Assisted members in scheduling appointments and eliminated barriers to attending appointments. • Implemented OB/GYN incentive program to incentivize OB/ GYNs for each prenatal and postpartum care gap they close. • Used quality practice advisors to conduct virtual and in-person provider visits to educate and improve prenatal and postpartum care rates. • Promote the use of Doula services through a partnership with a National Doula provider. • Implemented member healthy rewards for program for receipt of maternity visits. • Implemented ongoing text campaigns targeting prenatal and postpartum visit compliance. • Worked with community-based partners in hosting baby showers that connected members with resources in their community. • Used a maternal Child Services model that delivered a seamless, coordinated approach. From identification through care planning, trained staff sought to improve the overall quality of life, functional status, and health outcomes for pregnant members and their newborns.
HSAG recommends that the plans serving the MMA Program conduct a root cause analysis to determine why members who access the ED for mental illness or alcohol and other drug (AOD) abuse or dependence are not accessing or receiving timely follow-up care. HSAG recommends that the plans use the information learned from the root cause analysis to establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of	Plans identified the following actions in response to EQRO recommendations: • Implemented daily member outreach to confirm 7-day follow up appointments. • Offered telehealth follow-up visits when in-person visits were not available. • Developed interventions to enhance discharge planning, care transitions, and post-discharge care coordination, including member outreach and provider collaboration strategies.

HSAG Recommendation	Actions
telehealth services to ensure timely follow-up services. Additionally, HSAG recommends that the plans enhance communication and collaboration with hospitals to improve the effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with BH needs.	• Developed interventions to promote telehealth utilization and expansion to address lack of access and availability of appointments. • Developed interventions to enhance care coordination, education, and member and provider engagement post-ED visit. • Developed interventions to enhance efforts to obtain real-time ED visit notifications through Florida's ENS. • Utilized daily ENS notifications to follow-up with members identified with an inpatient facility or emergency room discharge. Identified members were assigned to the care transitions teams and/or assigned to a care manager for follow-up. Assigned care coordinator or care manager outreached identified members to assist with scheduling 7-day follow-up appointments and coordinated transportation if necessary. • Case managers provided resources to address social factors such as homelessness. • Care coordinators confirmed if a member was linked to a PCP or BH provider, assisted with scheduling of timely follow-up appointment within 7 days of discharge, scheduled transportation if needed, and called members to verify compliance w/appointment.
HSAG recommends that the plans serving the MMA Program conduct a root cause analysis or focus study to: • Determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness and identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness. Upon identification of a root cause, each plan should implement appropriate interventions to improve performance and in doing so, consider the nature and scope of the issue.	Plans identified the following actions in response to EQRO recommendations: • Contracted with value-based medication assistance providers. • Insourced behavioral health benefits. • Ensured timely identification of members that had transitioned after a short-term institutional stay to ensure receipt of services needed to remain in the community. • Conducted a series of meetings with behavioral health discharging facilities that focused on the *FUH* (*Follow-up after Hospitalization for Mental Illness*) and *FUM/FUA* metrics (for those with ED departments). During the meetings, engaged the facilities in discussion around barriers organization faced to get individuals an appointment prior to discharge, introduced benefits they may not be aware of, and partnered with facilities to link enrollees to those benefits. During those meetings promoted telehealth, specifically introducing the telehealth partner to address any issues with accessibility.

HSAG Recommendation	Actions
	• Conducted a root cause analysis on the *Initiation of Alcohol or Other Drug Abuse or Dependence* (AOD) *Treatment* and *Engagement of AOD Treatment* which noted a trend in PCPs diagnosing enrollees with a new AOD diagnosis. The *Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence (IET)* root cause analysis indicated that many PCPs were diagnosing enrollees with an AOD, but not ensuring SUD treatment was being initiated within 14-days of the diagnosis. Additional analysis resulted in identifying the top medical groups diagnosing enrollees with SUD in outpatient level of care year-over-year.
HSAG recommends that the plans serving the LTC Program evaluate their care coordination processes to determine whether there are opportunities to enhance the methods in which the plans engage with members and facilities to support successful discharges to the community. Additionally, plans should assess if they have adequate community supports in place to facilitate members successfully transitioning to reside in a community setting within 100 days of admission to a facility.	Plans identified the following actions in response to EQRO recommendations: • Developed and piloted interventions to enhance person-centered discharge planning, care transitions, and post-discharge care coordination, including member outreach and facility and community support services' collaboration strategies. • Community Connectors assisted members with housing needs and additional resources. • Developed partnerships that provided the CMs full chart access to the facilities that used specific accessible software. • Designed transition of care (TOC) programs that focused on coordination and communication during a member's admission and through the post discharge period. This gave members a single point of contact to assist the member in becoming an active participant in their care, ensured access to needed care and addressed potential barriers. • Created partnership with Centers for Independent Living (CILS) to help support successful transitions to the community. • Created a nursing home diversion program that focused on care transitions between inpatient settings (hospitalization, rehab and custodial). • Conducted nursing home audits for every new nursing home member enrollment to identify transition opportunities.
HSAG recommends that the dental plans conduct a root cause analysis or focus study to determine any barriers that prevent children from receiving a dental treatment service to	Plans identified the following actions in response to EQRO recommendations: • Continued to recruit new providers and engaged existing providers in order to increase capacity.

HSAG Recommendation	Actions
prevent dental caries, which is one of the most common chronic diseases.	• Opened new dental offices. • Reimbursed providers for using teledentistry. • Launched initiatives that directly and indirectly benefited the *ADV* rates. Examples included pay-for-performance provider incentive programs; text message outreach campaigns to encourage utilization; telephonic outreach to encourage utilization; dedicated community outreach unit that conducts in-person outreach, provides dental benefits and dental health education, and provides dental screenings (by the appropriately licensed/certified staff); and programs that inform enrollees of the importance of dental health by incentivizing them to practice healthy dental habits, such as practicing good oral hygiene and utilizing their dental benefits. • Continued to expand and devote more resources to case management (CM) departments as well as continued to engage the population from previously developed outreach methods. • Implemented various process improvements that occurred during the look-back period within case management triage and risk stratification work plan that included transportation events, medical record events, dental record events, nursing care plan events, and unable to contact events. These enhancements allowed staff to document more concisely based on CM obligations and to better audit member records for internal and external resources. • Increased size and capacity of case management.
Review of Compliance with Standards	
HSAG recommends that the Agency implement its planned process to conduct compliance reviews of all plans within the required three-year cycle. The Agency should use the tools provided by HSAG to ensure that all standards required in the CMS Medicaid Managed Care Rule are reviewed during the compliance reviews. Complete results of each plan's compliance reviews and follow-up on corrective actions should be submitted to HSAG annually to demonstrate compliance with conducting compliance reviews.	The Agency completed a full compliance review of all health plans on June 27, 2023. A combination of desk reviews, interviews, and virtual site visits was conducted. Plan-specific results were provided to the EQRO. The Agency will continue routine monitoring to ensure any deficiencies are corrected with each plan. The Agency agrees to continue efforts to ensure compliance.

HSAG Recommendation	Actions
Encounter Data Validation	
HSAG recommends that the Agency work closely with the plans to address any identified data discrepancies between the Agency- and plan-submitted encounters, in addition to continuing its current efforts in monitoring encounter data submissions.	The Agency regularly meets with plans to address common denials or ICNs supplied by the plans that were denied in FMMIS. Identifying why the encounter passed the plan's system but not FMMIS helps to identify data discrepancies between Agency encounters and plan claims.
HSAG recommends that the Agency collaborate with the specific plan (with NPI/PML discrepancies) to investigate the accuracy of the NPI information and understand the impact of PML updates on the differences observed.	The Agency will review the Gainwell Health Plan Support Team meeting notes from meetings with Simply, the plan identified in Appendix C to have this issue, to determine what has already been covered on this topic. Building on this, the Agency will outreach to Simply.
HSAG recommends that the Agency consider denied encounters as required for submission due to the importance of accurately reporting the services that have been provided.	The Agency stated that this recommendation has been considered and presented to the plans in an amendment (July 2022) but was subsequently removed before execution. The Agency will continue to consider it.
HSAG recommends that the Agency work with the specific plan(s) (for which key data elements had low accuracy rates) in resolving how the associated data element(s) should be submitted, collected, and reported.	The Agency will work individually with those health plans who have low accuracy rates in their LTC encounter data.
HSAG suggests working more collaboratively with the Agency's systems experts responsible for managing the encounter processing system at the initiation of the study. This will help HSAG to better understand the Agency's internal processing so that information can be shared with the plans when requesting data for the study.	The Agency responded that when the next study begins, the Agency will include the appropriate systems' subject matter experts in kickoff and initial meetings with the intent of increased collaboration throughout the study period.

Plan-Specific Assessment

Appendix E contains a summary of the follow-up actions per activity that the plans completed in response to HSAG's SFY 2020–2021 recommendations. The Agency, with assistance from HSAG, has developed a process in which all plans are required to response to each EQRO recommendation, including an assessment of why weaknesses exist, what improvement initiatives the plan initiated, and progress made.

Please note that the responses in Appendix E were provided by the plans and have not been edited or altered by HSAG. The Agency reviews plan responses to identify and implement programmatic QI efforts.

The following list includes shortened names and abbreviations for the plans.

COMPREHENSIVE PLANS

- Aetna Better Health of Florida, Inc. (*Aetna-C / AET-C*)
- Humana Medical Plan, Inc. (*Humana-C / HUM-C*)
- Molina Healthcare of Florida, Inc. (*Molina-C / MOL-C*)
- Simply Healthcare Plans, Inc. (*Simply-C / SIM-C*)
- Sunshine State Health Plan, Inc. (*Sunshine-C / SUN-C*)
- UnitedHealthcare of Florida, Inc. (*United-C / UNI-C*)

SPECIALTY PLANS

- Children's Medical Services Network[A-1] (*Children's Medical Services-S / CMS-S*)
- Clear Health Alliance (HIV/AIDS Specialty Plan) (*Clear Health-S / CHA-S*)[A-2]
- Molina Specialty Plan SMI (*Molina-S / MOL-S*)
- Sunshine Child Welfare Specialty Plan (*Sunshine-S-CW / SUN-S-CW*)
- Sunshine SMI Specialty Plan (*Sunshine-S-SMI / SUN-S-SMI*)

MANAGED MEDICAL ASSISTANCE (MMA) PLANS[A-3]

- AmeriHealth Caritas Florida, Inc. (*AmeriHealth-M / AMH-M*)
- South Florida Community Care Network, DBA Community Care Plan (*Community Care Plan-M / CCP-M*)

LONG-TERM CARE (LTC) PLUS PLAN

- Florida Community Care, LLC (*Florida Community Care-L / FCC-L*)

DENTAL PLANS

- DentaQuest of Florida (*DentaQuest-D / DQT-D*)
- Liberty Dental Plan of Florida (*Liberty-D / LIB-D*)
- Managed Care of North America (*MCNA-D / MCA-D*)

[A-1] Operated by Sunshine State Health Plan, Inc.
[A-2] Operated by Simply Healthcare Plans, Inc.
[A-3] On 11/1/2022, Best Care Assurance DBA Vivida Health (Vivida-M / VIV-M) was acquired by Simply.

Assessment of Compliance With Medicaid Managed Care Regulations

Compliance reviews are mandatory activities used to determine the extent to which Medicaid and CHIP MCPs are in compliance with federal standards. Federal regulations require MCPs to undergo a review at least once every three years to determine their compliance with federal standards as implemented by the state. Table B-1 describes the Agency's review cycle for the Compliance Reviews.

Table B-1—Summary of Compliance Standards and Associated Regulations

Year One: January 1, 2022—December 30, 2022 Accreditation/ Nonduplication Review, Document Updates, Ad Hoc Requests, and Desk Review Kick-Off	
Date/ Date Range	**Milestone/Interval Description**
2/2/22–2/25/22	**Agency identified trusted sources for info from previous review cycle and IDs updates needed**
2/16/2022	**Request sent to health and dental plans to verify accreditation information is complete and accurate**
3/1/2022	**Accreditation information shared with HSAG:** The Health Services Advisory Group, Inc. (HSAG) is the Agency's External Quality Review (EQR) vendor.
3/2/2022–4/7/2022	**HSAG updates agency review tools with plan accreditation information and appropriate contract citations**
4/8/2022	**HSAG submits updated review tools and all-plan accreditation summary to Agency**
4/15/2022–7/29/2022	**Agency updates plan-specific managed care rule review tools with trusted sources and subject matter experts involved in those reviews.** The agency maintains a managed care rule review tool for each health and dental plan. The tools have managed care rule requirements crosswalked with state contract requirements, and items deemed "met" due to plan accreditation. Agency staff use these tools during desk reviews to note which items are "met" or "not met" for the plan being reviewed.
8/15/2022–12/16/2022	**Agency identifies items to be requested from health and dental plans for desk reviews and develops ad hoc request letters**
11/16/2022	**Agency begins desk reviews for items that are already available/routinely submitted by plans**
12/19/2022	**Managed care rule compliance review ad hoc request letters sent to health plans:** The Agency sends ad hoc request letters to health plans for items that are not routinely submitted or already available to the Agency for review.

Year Two: January 1, 2023–December 30, 2023 Plan Submission, Desk Reviews, On-Sites, and Annual Technical Report	
Date/ Date Range	**Milestone/Interval Description**
1/13/2023	**Health Plan Submissions Due to the Agency**
2/1/2023	**Agency sends Ad Hoc request to dental plans**
2/22/2023	**Dental plan ad hoc submissions due**
2/8/2023–3/24/2023	**Agency reviews health & dental plan ad hoc submissions**
4/3/2023	**Agency sends deficiency letters to plans (Health and Dental):** Site visit agenda topics are based on deficiencies identified during desk reviews
5/1/2023–5/12/2023	**Virtual Site Visits Conducted & Agency shares site visit findings**
5/2/2023–5/25/2023	**Plans submitted evidence to demonstrate compliance with deficiencies & functional area staff review to confirm compliance**
7/5/2023–9/20/2023	**Agency compiles managed care rule compliance documentation for annual technical report and routes internally**
9/29/2023	**Agency submits desk review findings, site visit details, and corrective action outcomes to HSAG for 2024 Annual Technical Report**
10/3/2023–12/23/2023	**HSAG drafts the Managed Care Rule Compliance section of 2024 Annual Technical Report to be posted/submitted to CMS in April of 2024**
Year Three: January 1, 2024 – December 30, 2024 Review Cycle Closeout and Year Three Annual Technical Report	
1/12/2024	**HSAG submits draft 2024 Annual Technical Report to the Agency**
1/15/2024–3/29/2024	**Draft 2024 Annual Technical Report routes through Agency**
4/1/2024	**2024 Annual Technical Report submitted to CMS/ posted to Agency website**
7/1/2024	Agency gathers lessons learned from 2022–2024 review cycle; begins strategy development for 2025–2027 review cycle.
9/30/2024–12/31/2024	**HSAG draft2025 Annual Technical Report**

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. During CY 2023–2024 the Agency will conduct a full review of the Part 438 Subpart D and QAPI standards for all plans to ensure compliance with federal requirements. The objective of each review is to provide meaningful information to the Agency and the plans regarding:

- The plans' compliance with federal managed care regulations and contract requirements in the areas selected for review.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the plans into compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to care and services furnished by the plans, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the plans' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

Beginning February 2, 2022, the Agency began to identify trusted sources of information from the previous review cycle and identification updates as needed. The Agency completed these tasks on February 25, 2022. Meanwhile, on February 16, 2022, the Agency requested that health and dental plans verify accreditation information, to ensure that it was complete and accurate.

On March 1, 2022, the Agency shared the health and dental plan accreditation information with the HSAG and the Agency's EQRO. On March 2, 2022, HSAG began updating the Agency's review tools with health and dental plan accreditation information and appropriate contract citations. This task was completed on April 7, 2022, and was submitted to the Agency along with the all-plan accreditation summary on April 8.

Subsequently, on April 15, 2022 the Agency began working with trusted sources and subject matter experts to update plan-specific managed care rule review tools. The Agency maintains a managed care review tool for each health and dental plan. These tools have managed care rule requirements cross-walked with state contract requirements and items that have been deemed "met" due to plan accreditation. Agency staff use these tools during desk review to note which items are "met" or "not met" for the plan under review. The updates to these tools were completed on July 29, 2022.

On August 15, 2022, the Agency began identifying information required from health and dental plans needed to complete desk reviews, which was completed on December 16, 2022. Meanwhile, the Agency also began to develop ad hoc request letters for the information needed from the health and dental plans. On November 16, 2022, the Agency began to perform desk reviews with the information that had was readily available, and continued these reviews as new information was received. On December 19, 2022, the Agency sent ad hoc request letters to health plans for information that is not routinely submitted or readily available with a due date of January 1, 2023. The Agency sent the ad hoc request letters to dental plans on February 1, 2023, with a due date of February 22, 2023. Once received, the Agency reviewed the health and dental plan ad hoc submissions beginning February 8, and concluding on March 24, 2023. After the ad hoc review, the Agency drafted deficiency letters for both health and dental plans, which were distributed on April 3, 2023.

The Agency then conducted virtual site visits and shared its findings with the health and dental plans beginning on May 1, and concluding on May 12, 2023. The agendas for these site visits were determined by the deficiencies the Agency had previously identified during desk reviews. Beginning May 2, 2023,

health and dental plans were able to submit evidence to demonstrate compliance with the identified deficiencies with a deadline of May 25, 2023. Once the evidence was received, functional area staff reviewed the information to confirm compliance.

The Agency began compiling managed care rule compliance documentation for the Annual Technical Report on July 5, 2023. This documentation was then routed internally for approval, which was received on September 20, 2023. The Agency then submitted desk review findings, site visit details, and corrective action outcomes to HSAG for the 2024 Annual Technical Report on September 29, 2023. Beginning on October 3, 2023, HSAG drafted the Managed Care Rule Compliance section of the 2024 Annual Technical Report. HSAG completed this section on October 23, 2023, and submitted the draft of the 2024 Annual Technical Report to the Agency on January 17, 2024.

On January 17, 2024, the Agency began routing the draft 2024 Annual Technical Report internally for approval. The Agency intends to submit the 2024 Annual Technical Report to CMS and post to The Agency website by April 30, 2024.

The Agency will gather lessons learned from the 2022-2024 review cycle and begin to develop a strategy for the 2025-2027 review cycle.

PMV Methodology

HSAG followed two technical methods: one method for the MMA program and one method for the LTC program. For the MMA program, HSAG requested the performance measure report and the FAR generated by the LO for each plan. These documents, which were used and/or generated by the 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.

MMA Program

Table B-2 presents critical elements and approaches that HSAG used to conduct the PMV activities for the plans.

Table B-2—Key PMV Steps Performed by HSAG for the 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 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.

PMV Step	Associated Activities Performed by HSAG
Software Vendor	If a plan used a software vendor to produce measure indicator rates, HSAG assessed whether the plan contracted with a vendor that achieved NCQA Measure Certification[SM,B-1] 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).
Source Code Review	HSAG ensured that if a software vendor with HEDIS Certified Measures[SM, B-2] was not used, the LOs reviewed the 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 indicator rates.
Supplemental Data Validation	If the plan used any supplemental data for reporting, the LO was to validate the supplemental data according to NCQA's guidelines. HSAG verified whether 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 plan was 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.
Plan Quality Indicator Data File Review	The plans are required to submit a plan quality indicator data file for the submission of audited rates to the Agency. The file should comply with the Agency-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 plan quality indicator data file.

[B-1] NCQA Measure Certification[SM] is a service mark of the NCQA.
[B-2] HEDIS Certified Measures[SM] is a service mark of the NCQA.

LTC Program

For the LTC program, HSAG obtained a list of the performance measures specified in the SMMC program contract that were required for validation.

HSAG requested the FAR and performance measure report generated by the auditor for each plan. The performance measure report contained all rates calculated and reported by the plan. According to the Agency's reporting requirements, these rates were also audited by the plan's LO.

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 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 the Agency.
- 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 for which NCQA HEDIS Compliance Audit procedures were not referenced in the FAR.

Validation Audit

HSAG also validated the 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.

PIP Validation Approach and Methodology

Objectives

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a

reasonable time. This structured method of assessing and improving plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a plan’s compliance with the requirements of 42 CFR §438.330(d)(2) including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG’s PIP validation is to ensure that the Agency and key stakeholders can have confidence that any reported improvement is related and can be reasonably linked to the QI strategies and activities conducted by the health and dental plans during the PIP.

Technical Methods of Data Collection

HSAG obtained the data needed to conduct the PIP validation from each plan’s PIP Submission Form. Each plan completed the form for PIP activities conducted during MY and submitted it to HSAG for validation. The PIP Submission Form presents instructions for documenting information related to each of the CMS Protocol 1 steps. The plans could also attach relevant supporting documentation with the PIP Submission Form.

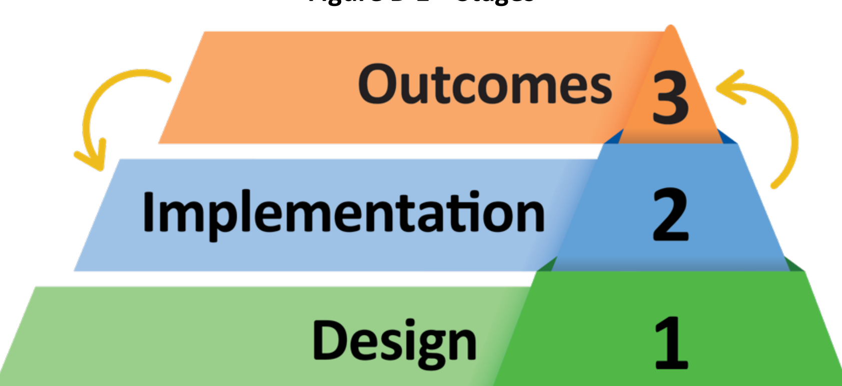
Description of Data Obtained

The plans used the Agency-provided specifications to calculate the performance indicator rates of the Administration of the Transportation Benefit PIP and used HEDIS specifications for reporting the FUH, FUM, and FUA measures for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP.

The dental plans used the Agency-provided specifications for the Coordination of Transportation Services with SMMC Plans PIP and CMS Child Core Set PDENT-CH measure specifications for the Preventive Dental Services for Children PIP.

Figure B 1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage (Steps 1 through 6) establishes the methodological framework for the PIP. The steps in this section include development of the PIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP design is necessary.

Figure B-1—Stages



Once a plan establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7 and 8). During this stage, the plan evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically, clinically, or programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline performance over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, plans should revise their causal/barrier analysis processes and adapt QI strategies and interventions accordingly.

How Data Were Aggregated and Analyzed

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS Protocol 1. With the Agency's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool was used to evaluate each of the PIPs for the following nine CMS Protocol 1 steps:

Table B-3—CMS Protocol Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood That Significant and Sustained Improvement Occurred

Each required step was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. Plans would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides *Validation Feedback* with a *Me*t validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

How Conclusions Were Drawn

HSAG's methodology for assessing and documenting PIP findings provides a consistent, structured process and a mechanism for providing the plans with specific feedback and recommendations for the PIP. Using its PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

Met = high confidence/confidence in the reported findings
Partially Met = low confidence in the reported findings
Not Met = reported findings are not credible

PIP Submission Form

A sample PIP submission form used for data collection is displayed on the following pages.

Demographic Information	
MCO Name: _____	
Project Leader Name: _____	Title: _____
Telephone Number: _____	Email Address: _____
PIP Title: *<PIP Topic>*	
Submission Date: _____	
Resubmission Date (if applicable): _____	

Step 1: Select the PIP Topic. The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State.
PIP Topic: **Provide plan-specific data:** **Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction:**

Step 2: Define the PIP Aim Statement(s). Defining the aim statement(s) helps maintain in the focus of the PIP and sets the framework for data collection, analysis, and interpretation. **The statement(s) should:** ◆ Be structured in the recommend X/Y format: "Does doing X result in Y?" ◆ The statement(s) must be documented in clear, concise, and measurable terms. ◆ Be answerable based on the data collection methodology and indicator(s) of performance
Statement(s):

Step 3: Define the PIP Population. The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.

The population definition should:

- Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria.
- Include the age range and the anchor dates used to identify age criteria, if applicable.
- Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step 3.
- Capture all members to whom the statement(s) applies.
- Include how race and ethnicity will be identified, if applicable.
- If members with special healthcare needs were excluded, provide the rationale for the exclusion.

Population definition:

Enrollment requirements (if applicable):

Member age criteria (if applicable):

Inclusion, exclusion, and diagnosis criteria:

Diagnosis/procedure/pharmacy/billing codes <u>used to identify the eligible population</u> (if applicable):

Step 4: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. **Sampling methods should be in accordance with generally accepted principles of research design and statistical analysis.** **<u>If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.</u>**

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each indicator.
- Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results.

Measurement Period	Performance Indicator Title	Sampling Frame Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample:

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. **The description of the Indicator(s) should:** ◆ Include the complete title of each indicator. ◆ Include the rationale for selecting the indicator(s). ◆ Include a narrative description of each numerator and denominator. ◆ If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually. ◆ Include complete dates for all measurement periods (with the month, day, and year). ◆ Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."	
Indicator 1	**[Enter Indicator title]**
	[Insert a narrative description, and the rationale for selection, of the indicator. Describe the basis on which the indicator was developed, if internally developed.]
Numerator Description:	
Denominator Description:	
Baseline Measurement Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 1 Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 2 Period	MM/DD/YYYY to MM/DD/YYYY
Mandated Goal/Target, if applicable	
Indicator 2	**[Enter Indicator title]**
	[Insert a narrative description, and the rationale for selection, of the indicator. Describe the basis on which the indicator was developed, if internally developed.]
Numerator Description:	

Step 5: Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. **The description of the Indicator(s) should:** ◆ Include the complete title of each indicator. ◆ Include the rationale for selecting the indicator(s). ◆ Include a narrative description of each numerator and denominator. ◆ If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually. ◆ Include complete dates for all measurement periods (with the month, day, and year). ◆ Include the mandated goal or target, if applicable. If no mandated goal or target enter "Not Applicable."	
Denominator Description:	
Baseline Measurement Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 1 Period	MM/DD/YYYY to MM/DD/YYYY
Remeasurement 2 Period	MM/DD/YYYY to MM/DD/YYYY
Mandated Goal/Target, if applicable	
Use this area to provide additional information.	

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.

The data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the indicator percentage.
- A copy of the manual data collection tool, if applicable.
- An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.

Data Sources (Select all that apply)

Manual Data	Administrative Data	Survey Data
[ ]Manual Data Data Source [ ] Paper medical record abstraction [ ] Electronic health record abstraction Record Type [ ] Outpatient [ ] Inpatient [ ] Other, please explain in narrative section. [ ] Data collection tool attached (required for manual record review)	[ ] Administrative Data Data Source [ ] Programmed pull from claims/encounters [ ] Supplemental data [ ] Electronic health record query [ ] Complaint/appeal [ ] Pharmacy data [ ] Telephone service data/call center data [ ] Appointment/access data [ ] Delegated entity/vendor data _______________ [ ] Other _____________________ Other Requirements [ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)-please attach separately [ ] Data completeness assessment attached [ ] Coding verification process attached	[ ] Survey Data Fielding Method [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Other ________________________ Other Survey Requirements: Number of waves: _______ Response rate: _______ Incentives used: ______

Step 6: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable. **The data collection methodology should include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the indicator percentage. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of the reported administrative data completeness percentage and the process used to determine this percentage.		
	Estimated percentage of reported administrative data completeness at the time the data are generated: _______ % complete. Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported:	

In the space below, describe the step-by-step data collection process used in the production of the indicator results:

Step 7: Indicator Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated **performance measure rate(s)**.

Enter results for each indicator by completing the table below. *P* values should be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary.

Indicator 1 Title: [Enter title of indicator]						
Measurement Period	**Indicator Measurement**	**Numerator**	**Denominator**	**Percentage**	**Mandated Goal or Target, if applicable**	**Statistical Test Used, Statistical Significance, and *p* Value**
MM/DD/YYYY–MM/DD/YYYY	***Baseline***				N/A for baseline	N/A for baseline
MM/DD/YYYY–MM/DD/YYYY	**Remeasurement 1**					
MM/DD/YYYY–MM/DD/YYYY	**Remeasurement 2**					
Indicator 2 Title: [Enter title of indicator]						
Time Period	**Indicator Measurement**	**Numerator**	**Denominator**	**Percentage**	**Mandated Goal or Target, if applicable**	**Statistical Test, Statistical Significance, and *p* Value**
MM/DD/YYYY–MM/DD/YYYY	***Baseline***				N/A for baseline	N/A for baseline
MM/DD/YYYY–MM/DD/YYYY	**Remeasurement 1**					
MM/DD/YYYY–MM/DD/YYYY	**Remeasurement 2**					

Step 7: Data Analysis and Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.

The data analysis and interpretation of indicator results should include the following for each measurement period:

- Data presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234).
- Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period, including the baseline measurement period, and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step 7.

Baseline Narrative:

Baseline to Remeasurement 1 Narrative:

Baseline to Remeasurement 2 Narrative:

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

Quality Improvement Team and Activities Narrative Description: Under the measurement period placeholder below corresponding to the most recent completed measurement period, add a description of the quality improvement team members, the causal/barrier analysis process, and quality improvement tools used to identify and prioritize barriers for each measurement period below.

Baseline Narrative:

Remeasurement 1 Narrative:

Remeasurement 2 Narrative:

Barriers/Interventions Table: In the table below, report prioritized barriers, corresponding interventions, and intervention details (initiation date, current status, and type.

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

Barrier Priority Ranking	Barrier Description	Intervention Initiation Date (MM/YY)	Intervention Description	Select Current Intervention Status	Select if Member, Provider, or System Intervention
				Click to select status	Click to select status
				Click to select status	Click to select status

Intervention Evaluation Table: In the table below, list each intervention that was included in the Barriers/Interventions Table, above. For each intervention, document the **processes and measures used to evaluate effectiveness**, the evaluation results, and next steps taken in response to the evaluation results. Additional documentation of evaluation processes and results may be attached as separate documents. Attachments should be clearly labeled and referenced in the table below.

Step 8: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.

This step should be updated for each measurement period by adding to existing documentation. Include the following:

- Quality Improvement Team and Activities Narrative Description
- Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions
- Intervention Evaluation Table: Evaluation of each intervention
- Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP

Measurement Period	Intervention Description	Evaluation Process	Evaluation Results	Next Steps

Clinical and Programmatic Improvement Table: In the table below, describe any clinical and/or programmatic improvement that was achieved at any remeasurement period during the PIP. Specify each remeasurement period when improvement was obtained and the intervention(s) that led to the improvement. Provide intervention evaluation results in the *Supporting Quantitative or Qualitative Data* column.

Clinical Improvement		
Remeasurement Period	**Narrative Summary of Clinical Improvement**	**Supporting Quantitative or Qualitative Data**
Programmatic Improvement		
Remeasurement Period	**Narrative Summary of Programmatic Improvement**	**Supporting Quantitative or Qualitative Data**

Encounter Data Validation

Objectives

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of the encounter data submissions to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information. The completeness and accuracy of these data are essential to the success of the state's overall management and oversight of its Medicaid managed care program and in demonstrating its responsibility and stewardship.

During SFY 2021–22, the Agency has contracted with HSAG to conduct an EDV study. The goal of the SFY 2021–22 EDV study is to examine the extent to which the LTC encounters submitted to the Agency by its contracted MMA and LTC plans (collectively referred to as plans) are complete and accurate. Table B-4 lists the contracted plans included in this study. This section describes the proposed methodology for the SFY 2021–22 EDV study.

Table B-4—List of Contracted Plans

Plan Name	Plan Abbreviation	Shortened Name
Comprehensive Plans		
Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	COV-C	Aetna
Humana Medical Plan, Inc.	HUM-C	Humana
Molina Healthcare of Florida, Inc.	MOL-C	Molina
Simply Healthcare Plans, Inc.	SIM-C	Simply
Sunshine State Health Plan, Inc.	SUN-C	Sunshine
United Healthcare of Florida, Inc.	URA-C	United
Wellcare of Florida d/b/a Staywell Health Plan of Florida, Inc.	STW-C	Staywell
LTC Plan		
Florida Community Care	FCC-L	Florida Community Care

Methodology

In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* October 2019,[B-1] HSAG will conduct the following core evaluation activities for the EDV activity:

- Comparative analysis—Analysis of the Agency's electronic encounter data completeness and accuracy through a comparison between the Agency's electronic encounter data and the data extracted from the plans' data systems.
- Clinical record and plan of care review—Analysis of the Agency's electronic encounter data completeness and accuracy by comparing the Agency's electronic encounter data to the information documented in the corresponding enrollees' clinical records and plans of care.

The SFY 2021–22 EDV study focused its review on the LTC encounter claim type.

Comparative Analyses

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to the Agency by the plans are complete and accurate based on corresponding information stored in the plans' data systems. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in CMS Protocol 5. The comparative analysis will be performed on the LTC encounters submitted by the plans with dates of service between January 1, 2020, and December 31, 2020. The LTC encounter data from the MMA comprehensive plans and the LTC plan will be included in the study. The comparative analysis component will involve three key steps:

- Develop data submission requirements documents outlining encounter data submission requirements for the Agency and the plans, including technical assistance sessions.
- Conduct a file review of submitted encounter data from the Agency and the plans.
- Conduct a comparative analysis of the encounter data.

Development of Data Submission Requirements and Technical Assistance

Following the Agency's approval of the scope of work, HSAG will prepare and submit data submission requirements documents to the Agency and the plans. These documents will include a brief description of the SFY 2021–22 EDV study, a description of the review period, requested encounter data type(s), required data fields, and the procedures for submitting the requested data files to HSAG. The requested encounter data files will include key data elements to be evaluated in the EDV study. The Agency and the plans will be requested to submit all LTC encounter data records with dates of service between January 1,

[B-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity,* February 2023. Available at: http://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 1, 2024.

2020 and December 31, 2020, and submitted to the Agency on or before July 31, 2021. This anchor date will allow enough time for CY 2020 encounters to be submitted, processed, and available for evaluation in the Agency's data warehouse.

HSAG will conduct a technical assistance session with the plans to facilitate the accurate and timely submission of data. The technical assistance session will be conducted approximately one week after distributing the data submission requirements document, thereby allowing the plans time to review and prepare their questions for the session. During this technical assistance session, HSAG's EDV team will introduce the SFY 2021–22 EDV study, review the data submission requirements document, and address all questions related to data preparation and extraction. Both the Agency and the plans will have approximately one month to extract and prepare the requested files for submission to HSAG.

Preliminary File Review

Following receipt of the Agency's and the plans' encounter data submissions, HSAG will conduct a preliminary file review to determine if any data issues existed in the data files that would warrant a resubmission. The preliminary file review will include the following checks:

- Data extraction—Extracted based on the data requirements document.
- Percent present—Required data fields are present on the file and have values in those fields.
- Percent of valid values—The values are the expected values; e.g., valid International Classification of Diseases, 10th Revision (ICD-10) codes in the diagnosis field.
- Evaluation of matching claim numbers—The percentage of claim numbers matching between the data extracted from the Agency's data warehouse and the plans' data submitted to HSAG.

Based on the results of the preliminary file review, any major discrepancies, anomalies, or issues identified in the encounter data submissions will be communicated to the affected plan(s) and/or the Agency. The plans or the Agency will subsequently resubmit data, if necessary.

Conduct the Comparative Analyses

Once final data from the Agency and the plans have been received and processed, HSAG will conduct a series of analyses. To facilitate the presentation of findings, the comparative analyses will be divided into two analytic sections.

First, HSAG will assess record-level data completeness using the following metrics:

- The number and percentage of records present in the files submitted by the plans that were not found in the files submitted by the Agency (***record omission***).
- The number and percentage of records present in the files submitted by the Agency but not found in the files submitted by the plans (***record surplus***).

Second, based on the number of records present in both data sources, HSAG will further examine completeness and accuracy for key data elements listed in Table B-5. The analyses will focus on an element-level comparison for each date element.

Table B-5—Key Data Elements for Comparative Analysis

Key Data Elements	LTC encounters from 837I	LTC encounters from 837P
Enrollee ID	√	√
Header Service From Date	√	√
Header Service To Date	√	√
Detail Service From Date	√	√
Detail Service To Date	√	√
Admission Date	√	
Discharge Date	√	
Billing Provider NPI	√	√
Attending Provider NPI	√	
Rendering Provider NPI		√
Referring Provider NPI	√	√
Primary Diagnosis Code	√	√
Secondary Diagnosis Code	√	√
Procedure Code (CPT/HCPCS/CDT)*	√	√
Procedure Code Modifier	√	√
Units of Service	√	√
Primary Surgical Procedure Code	√	
National Drug Code (NDC)	√	√
Revenue Code	√	
Diagnosis Related Group (DRG)	√	
Header Paid Amount	√	√
Detail Paid Amount	√	√

*CPT = Current Procedural Terminology, HCPCS = Healthcare Common Procedure Coding System, CDT = Current Dental Terminology

Element-level completeness will focus on an element-level comparison between both sources of data and address the following metrics:

- The number and percentage of records with values present in the files submitted by the plans but not present in the files submitted by the Agency (***element omission***).
- The number and percentage of records with values present in the files submitted by the Agency but not present in the files submitted by the plans (***element surplus***).

Element-level accuracy will be limited to those records with values present in both the Agency's and the plans' submitted files. For a particular data element, HSAG will determine:

- The number and percentage of records with exactly the same values in both the Agency's and the plans' submitted files (***element accuracy***).
- The number and percentage of records present in both data sources with exactly the same values for select data elements relevant to each encounter data type (***all-element accuracy***).

Technical Assistance

As a follow-up to the comparative analysis activity, HSAG will provide technical assistance to the plans regarding the issues identified from the comparative analysis. First, HSAG will draft plan-specific encounter data discrepancy reports highlighting key areas for investigation. Second, upon the Agency's review and approval, HSAG will distribute the data discrepancy reports to the plans, along with data samples to assist the plans with their internal investigations. Based on their internal investigations, plans will be required to identify potential root causes of the key issues and provide written responses to the data discrepancy reports. Lastly, once HSAG reviews the written responses, it will follow up with the plans, for any further clarification, if appropriate.

Clinical Record and Plan of Care Review

As outlined in CMS Protocol 5, record review is a complex, resource-intensive process. Clinical records (including medical and treatment-related records) are considered the "gold standard" for documenting Medicaid enrollees' access to and quality of services. The second component of the EDV study is an assessment of data quality through investigating the completeness and accuracy of the Agency's encounters compared to the information documented in the corresponding clinical records and plans of care of Medicaid enrollees.

The review of clinical records will include services rendered between January 1, 2020, and December 31, 2020. The clinical review component of the study will answer the following question:

- *Are the data elements in Table B-6 found on the LTC encounters complete and accurate when compared to information contained within the clinical records?*

Table B-6—Key Data Elements for Clinical Record Review

Key Data Elements	
Date of Service	Diagnosis Code
Procedure Code	Procedure Code Modifier

Additionally, for individuals receiving home and community-based services (HCBS) or care in LTC facilities (e.g., nursing homes), HSAG will review the associated Plan of Care documentation. The review will evaluate whether the LTC services reported in the encounters are supported by enrollees' plans of care. HSAG will review the Plan of Care documentation for alignment with authorization dates, scheduled services, units of service, and service providers. As such, the Plan of Care documentation review component of the study will answer the following questions:

- *Is there a valid plan of care? If so, is the plan of care document signed*?
- *Is the selected date of service within the effective dates of the plan of care*?
- *Is there a servicing provider documented in the plan of care*? *If so, is the servicing provider identified in the clinical record supported by the plan of care*?
- *Are the procedures documented in the clinical record supported by the plan of care*?
- *Are the number of units documented in the clinical record supported by the plan of care*?

To answer the study questions, the clinical record and plan of care review will involve the following key steps:

- Identify the eligible population and generate samples from data submitted by the Agency for the study.
- Assist plans to procure clinical records and plan of care documents from their LTC providers, as appropriate.
- Review clinical records and plan of care documents against the Agency's encounter data.
- Calculate study indicators based on the reviewed/abstracted data.
- Draft report based on study results.

Study Population

To be eligible for the clinical record and plan of care review, an enrollee must be continuously enrolled in the same plan during the study period (i.e., between January 1, 2020, and December 31, 2020), and must have had at least one LTC service during the study period. For plans that do not have members enrolled with the same plan continuously during the study period, HSAG will adjust the continuous enrollment accordingly. In addition, enrollees with Medicare or other insurance coverage will be excluded from the eligible population since the Agency does not have complete encounter data for all services they received. In this document, HSAG refers to LTC services as the services that meet all criteria in Table B-7. In addition, after reviewing the encounter data from the Agency's data warehouse, HSAG may discuss additional changes to these criteria with the Agency, as needed.

Table B-7—Criteria for LTC Services Included in the Study

Data Element	Criteria
LTC Services	
Claim Type	Claim Type Code = LTC
Provider Type	LTC provider types shall include but are not limited to:* 01 – General Hospital 05 – Community Behavioral Health Services 07 – Specialized Mental Health Practitioner 10 – Skilled Nursing Facility 12 – Private ICF/DD Facility 13 – Swing Bed Facility 14 – Assistive Care Services 15 – Hospice 23 – Medical Foster Care / Personal Care Provider 25 – Physician (M.D.) 26 – Physician (D.O.) 27 – Podiatrist 29 – Physician Assistant

Data Element	Criteria
	30 – Nurse Practitioner (ARNP) 31 – Registered Nurse / Registered Nurse First Assistant 32 – Social Worker / Case Manager 65 – Home Health Agency 66 – Rural Health Clinic 67 – Home and Community Based Services Waiver 68 – Federally Qualified Health Center 81 – Professional Early Intervention Services 83 – Therapist (PT, OT, ST, RT) 91 – Case Management Agency
Trading Partner Identifier (TPID)	TPIDs as listed in Table B-8

*MD = medical doctor, DO = doctor of osteopathic medicine, ARNP = advanced registered nurse practitioner, PT = physical therapist, OT = occupational therapist, ST = speech-language therapist, RT = respiratory therapist

Sampling Strategy

Encounter data, enrollment and demographic data, and provider data from the Agency used in the comparative analyses will be used to select the record review samples. HSAG will use a two-stage sampling technique to select samples based on the data received from the Agency. HSAG will first identify all enrollees who met the study population eligibility criteria. HSAG will then randomly select the enrollees by plan based on the required sample size. Then, for each selected sample enrollee, HSAG will use the SURVEYSELECT procedure in SAS®,[B-2] to randomly select one LTC visit[B-3] that occurred in the study period (i.e., January 1, 2020, through December 31, 2020).

The final sample used in the evaluation will consist of a minimum of 146 cases randomly selected per plan. If a plan has less than 146 cases that are eligible for the study, all of the eligible cases will be included for review. An additional 25 percent oversample (or 37 cases per plan) will be sampled to replace records not procured. As such, plans with an adequate number of cases eligible for the study will be responsible for procuring a minimum of 183 total sampled enrollees' clinical records and plan of care documents per plan (i.e., 146 sample and 37 oversample) from their contracted LTC providers for services that occurred during the study period.

Clinical Record and Plan of Care Record Procurement

Upon receiving the final sample list from HSAG, plans will be responsible for procuring the sampled enrollees' clinical records and plans of care from their contracted providers for services that occurred

[B-2] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.
[B-3] To ensure that the clinical record review includes all services provided on the same date of service, encounters with the same date of service and same rendering provider will be consolidated into one visit for sampling.

during the study period. In addition, plans will be responsible for submitting the documentation to HSAG. To improve the procurement rate, HSAG will conduct a one-hour technical assistance session with the plans to review the EDV project and the procurement protocols after distributing the sample list. Plans will be instructed to submit the clinical records and plan of care documents electronically via a secure file transfer protocol site to ensure the protection of personal health information. During the procurement process, HSAG will work with the plans to answer questions and monitor the number of clinical records and plan of care documents submitted. For example, HSAG will provide an initial submission update when 40 percent of the documentation is expected to be submitted and a final submission status update following completion of the procurement period.

All electronic clinical records and plan of care documents that HSAG receives will be maintained on a secure site, which will allow HSAG's trained reviewers to validate the cases from a centralized location under supervision and oversight. As with all record reviews and research activities, HSAG has implemented a thorough Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and protection program in accordance with federal regulations which includes recurring training as well as policies and procedures that address physical security, electronic security, and day-to-day operations.

Review of Clinical Records and Plan of Care Documents

Concurrent with record procurement activities, HSAG will develop detailed training documents for the record review activity, train its review staff on specific study protocols, and conduct interrater reliability (IRR) and rate-to-standard testing. All reviewers must achieve a 95 percent accuracy rate prior to reviewing clinical records and plan of care documents and collecting data for the study.

During the clinical record and plan of care document review activity, HSAG's trained reviewers will collect and document findings in an HSAG-designed electronic data collection tool. IRR among reviewers, as well as reviewer accuracy, will be evaluated regularly throughout the study. Questions raised and decisions made during this evaluation process will be documented and communicated to all reviewers in a timely manner. In addition, HSAG analysts will periodically review the export files from the abstraction tool to ensure the abstraction results are complete, accurate, and consistent.

Clinical Record Review Indicators and Plan of Care Document Review Findings

Once the record review is completed, HSAG analysts will export information collected from the electronic tool, review the data, and conduct the analysis. HSAG will use four study indicators of data completeness and accuracy to report the record review results:

- ***Record/documentation omission rate***: the percentage of sampled dates of service identified in the electronic encounter data that are not found in the enrollees' clinical records. HSAG will also calculate this rate for the other key data elements in Table B-6.
- ***Encounter data omission rate***: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the enrollees' clinical records that are not found in the electronic encounter data.

- ***Accuracy rate of coding***: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that are correctly coded based on the enrollees' clinical records.
- ***Overall accuracy rate****:* the percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

In addition to the clinical-related indicators, based on reviews of the plan of care documents, findings that include an evaluation of whether the LTC services documented for the selected dates of service are supported by the plans of care will be presented.

Reporting of Results

Based on the findings from the comparative analyses and the clinical record review, HSAG will prepare an aggregate EDV report. The main section will focus on the presentation of statewide average results with plan variations. The plan-specific results will be listed in the appendix for each plan. The comparative analyses and clinical record review findings will be provided along with recommendations to improve the quality of encounter data.

Prior to drafting the aggregate report, HSAG will submit a report outline to the Agency for review and approval. The draft report will follow the CMS EQR Protocol 5 to include key findings, conclusions, and recommendations. Based on the findings and experience working with other states, HSAG will provide recommendations that are specific and actionable. HSAG will submit the draft report to the Agency for review based on a mutually agreeable project timeline so that the Agency staff will have sufficient time to review. HSAG will then incorporate the Agency's feedback and deliver the final report.

Table B-8—List of Plans Included in the EDV Study

Plan Name	Plan Abbreviation	Shortened Name	Trading Partner Identifier (TPID)	Plan Base Medicaid ID
MMA Comprehensive Plans				
Coventry Health Care of Florida, Inc. d/b/a Aetna Better Health of Florida	COV-C	Aetna	301823	1001200
Humana Medical Plan, Inc.	HUM-C	Humana	301826	1000513
Molina Healthcare of Florida, Inc.	MOL-C	Molina	301827	1001399
Simply Healthcare Plans, Inc.	SIM-C	Simply	301828	1001206
Sunshine State Health Plan, Inc.	SUN-C	Sunshine	301865	1000516
United Healthcare of Florida, Inc.	URA-C	United	301829	1001219
Wellcare of Florida d/b/a Staywell Health Plan of Florida, Inc.	STW-C	Staywell	301830	1000545
LTC Plan				
Florida Community Care	FCC-L	Florida Community Care	301860	1000536

Appendix C. Plan-Specific Strengths, Weaknesses, and Recommendations

Introduction

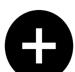
This section summarizes an assessment of each plan's strengths and weaknesses for the quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries and recommendations for improving the quality of healthcare services furnished by each plan, as required by 42 CFR §438.364. HSAG utilized the same method for aggregating and analyzing data for this section as described in the Executive Summary. CMS guidance encourages that when weaknesses are identified, the technical report should include the EQRO's understanding of why the weakness exists. To ensure thorough analysis on the plan-level, the Agency requires plans to describe why weaknesses, identified by the EQRO, exist. This analysis is included in Appendix E. HSAG and the Agency utilize this information to identify overarching trends, determine common causes, develop recommendations to address the deficiencies, and implement improvement efforts.

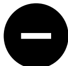
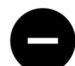
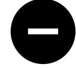
Plan-Specific Conclusions

Comprehensive Plans

Aetna-C

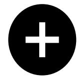
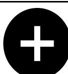
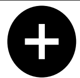
Strengths Related to Quality and/or Access and/or Timeliness	
+	Aetna-C provided FARs that contained IS capability findings and Aetna-C was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
+	Aetna-C's rates met or exceeded the MY 2022 performance targets for the following measure indicators: • *Childhood Immunization Status—Combination 3* • *Childhood Immunization Status—Combination 7* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Well-Child Visits in the First 30 Months of Life* (both indicators) • *Chlamydia Screening in Women—Total (16–24 Years)* • *Prenatal and Postpartum Care—Postpartum Care* • *Asthma Medication Ratio—Total* • *Kidney Health Evaluation for Patients with Diabetes—Ages 18–64 Years* and *Kidney Health Evaluation for Patients with Diabetes—Ages 65–74 Years*

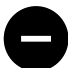
	Strengths Related to Quality and/or Access and/or Timeliness
	Aetna-C's rates met or exceeded the MY 2022 performance targets for both *LTSS Comprehensive Assessment and Update* measure indicators, both *LTSS Comprehensive Care Plan and Update* measure indicators, and *LTSS Shared Care Plan with Primary Care Practitioner (PCP)—Shared Care Plan with PCP*.
	Aetna-C reported achievement of statistically significant improvement over the baseline for the Administration of the Transportation Benefit PIP.
	For the EDV, Aetna-C's record surplus rates were low (i.e., at or lower than 5.0 percent) for the LTC institutional encounters. For the LTC professional encounters, Aetna-C's record omission and surplus rates were low, suggesting low discrepancies at the record level when comparing the plan-submitted files to the Agency-submitted files. Aetna-C's EDV results indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and LTC institutional encounters.

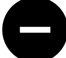
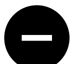
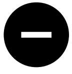
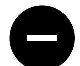
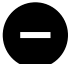
	Weaknesses and Recommendations
	**Weakness:** Aetna-C's rate fell below the MY 2022 minimum performance target for the *Childhood Immunization Status (CIS)—Combination 10* measure indicator. **Recommendations:** HSAG recommends that Aetna-C identify best practices for ensuring children receive medically appropriate preventive influenza vaccinations. HSAG recommends that Aetna-C review interventions that resulted in the plan meeting or exceeding the *CIS—Combination 3* and *CIS—Combination 7* performance targets and determine if similar interventions could be used to target the additional immunizations in the *CIS—Combination 10* measure indicator.
	**Weakness:** Aetna-C's rate fell below the MY 2022 minimum performance target for the *Medical Assistance with Smoking and Tobacco Use Cessation* measure (two of three indicators). **Recommendations:** HSAG recommends that Aetna-C conduct further analysis or a focus study to determine why providers are not discussing and/or recommending cessation medications with their patients. Upon identification of a root cause, HSAG recommends that Aetna-C implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation medication counseling.
	**Weakness:** Aetna-C had six measure indicator rates in the Behavioral Health domain, fall below the MY 2022 minimum performance targets, including the *Follow-Up After Emergency Department Visit for Mental Illness* measure and the *Follow-Up After Hospitalization for Mental Illness* measure. **Recommendations:** To improve follow-up after members access the ED or are hospitalized for mental illness, HSAG recommends that Aetna-C conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that Aetna-C enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs. HSAG recommends that Aetna-C partner with its contracted providers to identify

Weaknesses and Recommendations	
⊖	barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
⊖	**Weakness:** Aetna-C's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure. **Recommendations:** HSAG recommends that Aetna-C conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Aetna-C implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.
⊖	**Weakness:** Aetna-C's rates also fell below the MY 2022 performance targets for the following measure indicators: • *Eye Exam for Patients with Diabetes* • *Antidepressant Medication Management* (both indicators) • *Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total* **Recommendations:** HSAG recommends that Aetna-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
⊖	**Weakness:** For both PIPs, opportunities for improvement were noted for Aetna-C in the documentation of the statistical testing results, intervention evaluation data, and achievement of significant improvement in PIP outcomes. In addition, Aetna did not report achievement of statistically significant improvement for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. **Recommendations:** HSAG recommends that Aetna-C revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Aetna-C ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that Aetna-C consider seeking enrollee input to better understand enrollee-related barriers toward access to care.
⊖	**Weakness:** Aetna-C's record omission rate for LTC institutional encounters was 6.7 percent, which was higher than the 5.0 percent threshold, suggesting noticeable discrepancies at the record level when comparing the plan-submitted files to the Agency-submitted files. **Recommendations:** HSAG recommends that Aetna-C work closely with the Agency to address any identified data discrepancies between the Agency- and plan-submitted encounters.

Humana-C

	Strengths Related to Quality and/or Access and/or Timeliness
	Humana-C provided FARs that contained IS capability findings and Humana-C was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
	Humana-C's rates met or exceeded the MY 2022 performance targets for the following measure indicators: • *Childhood Immunization Status—Combination 7* • *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication—Continuation and Maintenance Phase* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* • *Chlamydia Screening in Women—Total (16–24 Years)* • *Blood Pressure Control for Patients with Diabetes* • *Controlling High Blood Pressure* • *Hemoglobin A1c Control for Patients with Diabetes (both indicators)* • *Kidney Health Evaluation for Patients with Diabetes* (three of four indicators)
	Humana-C's rates met or exceeded the MY 2022 performance targets for both *LTSS Comprehensive Assessment and Update* measure indicators and both *LTSS Comprehensive Care Plan and Update* measure indicators.
	Humana-C reported achievement of statistically significant improvement over baseline for the *Administration of the Transportation Benefit* PIP and the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP for one of three performance indicators.
	For the EDV, Humana-C's LTC professional encounters record omission and surplus rates were low, suggesting low discrepancies at the record level when comparing the plan-submitted files to the Agency-submitted files. Humana-C's EDV results also indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and institutional encounters.

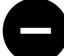
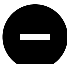
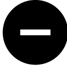
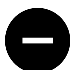
	Weaknesses and Recommendations
	**Weakness:** Humana-C's rate fell below the MY 2022 minimum performance target for the *CIS—Combination 10* measure indicator. **Recommendations:** HSAG recommends that Humana-C identify best practices for ensuring children receive medically appropriate preventive influenza vaccinations. HSAG recommends that Humana-C review interventions that resulted in the plan meeting or exceeding the *CIS—Combination 7* performance target and determine if similar interventions could be used to target the additional immunizations in the *CIS—Combination 10* measure indicator.

Weaknesses and Recommendations	
	**Weakness:** Humana-C's rate fell below the MY 2022 minimum performance target for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator. **Recommendations:** HSAG recommends that Humana-C consider the health literacy of the population served, as well as their capacity to access prenatal care, when designing strategies to improve performance rates. In addition, HSAG recommends that Humana-C consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Humana-C implement appropriate interventions to reduce barriers to care.
	**Weakness:** Humana-C's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure. **Recommendations:** HSAG recommends that Humana-C conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Humana-C implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	**Weakness:** Humana-C's rates also fell below the MY 2022 minimum performance targets for the following measure indicators: • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* • *Antidepressant Medication Management* (both indicators) • *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (6+ Years)* • *Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total* **Recommendations:** HSAG recommends that Humana-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure. Humana-C should review interventions that resulted in the plan meeting or exceeding the *CIS—Combination 7* performance target and determine whether similar interventions could be used to target the *Immunizations for Adolescents—Combination 1* measure indicator.
	**Weakness:** Humana-C did not meet the MY 2022 performance target for the *LTSS Shared Care Plan with Primary Care Practitioner—Shared Care Plan with PCP* measure. **Recommendations:** HSAG recommends that Humana-C evaluate opportunities to enhance care coordination with PCPs. HSAG recommends that Humana-C partner with its contracted providers to identify barriers that impede the plan from following recommended guidelines to share care plans with PCPs.
	**Weakness:** Humana-C did not report achievement of significant clinical improvement or programmatic improvement for either PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that Humana-C revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Humana-C ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that Humana-C

	Weaknesses and Recommendations
⊖	consider seeking enrollee input to better understand enrollee-related barriers toward access to care.
⊖	**Weakness:** Humana-C's record omission and surplus rates for LTC institutional encounters were high, with rates of 17.0 percent and 9.7 percent, respectively. **Recommendations:** HSAG recommends that Humana-C work closely with the Agency to address any identified data discrepancies between the Agency- and plan-submitted encounters.

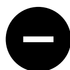
Molina-C

	Strengths Related to Quality and/or Access and/or Timeliness
	Molina-C provided FARs that contained IS capability findings and Molina-C was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
	Molina-C was one of the highest-performing plans in the Pediatric Care domain, with 12 measure indicator rates meeting or exceeding the performance targets.
	A majority of Molina-C's female members received critical screenings as rates for the following measures met or exceeded the MY 2022 performance targets: • *Cervical Cancer Screening—Cervical Cancer Screening* • *Chlamydia Screening in Women—Total (16−24 Years)* • *Breast Cancer Screening—Breast Cancer Screening*
	Molina-C's rates also met or exceeded the MY 2022 performance targets for the following measure indicators: • *Asthma Medication Ratio—Total* • *Blood Pressure Control for Patients With Diabetes* • *Controlling High Blood Pressure* • *Kidney Health Evaluation for Patients with Diabetes* (all four indicators) • *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* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
	Molina-C's rates met or exceeded the MY 2022 performance targets for both *LTSS Comprehensive Assessment and Update* measure indicators, both *LTSS Comprehensive Care Plan and Update* measure indicators. and *LTSS Shared Care Plan with Primary Care Practitioner (PCP)—Shared Care Plan with PCP*.
	Molina-C reported achievement of significant programmatic improvement for the Administration of the Transportation Benefit PIP and achievement of statistically significant improvement over the baseline for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP for one of three performance indicators.
	For the EDV, Molina-C's record surplus rates were low (i.e., at or lower than 5.0 percent) for the LTC institutional encounters. For LTC professional encounters, record omission rates and record surplus rates were low, suggesting low discrepancies at the record level when comparing the plan-submitted files to the Agency-submitted files. Molina-C's EDV results indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and LTC institutional encounters.

Weaknesses and Recommendations	
	**Weakness:** Molina-C's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure. **Recommendations:** HSAG recommends that Molina-C conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Molina-C implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	**Weakness:** For both PIPs, opportunities for improvement were noted for Molina-C in the documentation of the statistical testing results and intervention evaluation data. **Recommendations:** HSAG recommends that Molina-C's PIP/QI team include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions. HSAG recommends that Molina-C report complete intervention evaluation data as part of its PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission.
	**Weakness:** Molina-C did not report achievement of statistically significant improvement over the baseline or significant clinical improvement or programmatic improvement for the Administration of the Transportation Benefit PIP. Molina-C did not report significant clinical or programmatic improvement for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that Molina-C revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Molina-C ensure that data-driven decisions are made to revise the interventions to realize improvement. HSAG also recommends that Molina-C consider seeking enrollee input to better understand enrollee-related barriers toward access to care.
	**Weakness:** Molina-C's record omission rate for LTC institutional encounters was high, with a rate of 7.4 percent, which was higher than the 5.0 percent threshold. **Recommendations:** HSAG recommends that Molina-C work closely with the Agency to address any identified data discrepancies between the Agency- and plan-submitted encounters.

Simply-C

	Strengths Related to Quality and/or Access and/or Timeliness
+	Simply-C provided FARs that contained IS capability findings and Simply-C was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
+	Simply-C was the highest-performing plan in the Living with Illness domain, with 11 of the 13 reportable MY 2022 measure indicator rates meeting or exceeding the performance targets.
+	Simply-C's rates met or exceeded the MY 2022 performance targets for the following measure indicators: • *Childhood Immunization Status—Combination 3* • *Childhood Immunization Status—Combination 7* • *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication* • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Chlamydia Screening in Women—Total (16–24 Years)* • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
+	Simply-C's rates met or exceeded the MY 2022 performance targets for both *LTSS Comprehensive Assessment and Update* measure indicators, both *LTSS Comprehensive Care Plan and Update* measure indicators, and *LTSS Shared Care Plan with Primary Care Practitioner (PCP)—Shared Care Plan with PCP*.
+	Simply-C reported achievement of statistically significant improvement over the baseline and significant programmatic improvement for the Administration of the Transportation Benefit PIP. For the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP, Simply-C reported achievement of statistically significant improvement over baseline for one of three performance indicators, as well as significant clinical improvement and significant programmatic improvement.
+	For the EDV, Simply-C's record surplus rates were low (i.e., at or lower than 5.0 percent) for the LTC institutional encounters. For the LTC professional encounters, Simply-C's record surplus rates were low. Simply-C's EDV results indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and LTC institutional encounters

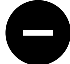
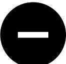
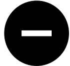
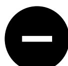
	Weaknesses and Recommendations
	**Weakness:** Simply-C's rate fell below the MY 2022 minimum performance target for the *CIS—Combination 10* measure indicator. **Recommendations:** HSAG recommends that Simply-C identify best practices for ensuring that children receive medically appropriate preventive influenza vaccinations. HSAG recommends that Simply-C review interventions that resulted in the plan meeting or exceeding the *CIS—Combination 3* and *CIS—Combination 7* performance targets and determine whether similar interventions could be used to target the additional immunizations in the *CIS—Combination 10* measure indicator.

Weaknesses and Recommendations	
⊖	**Weakness:** Simply-C's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure. **Recommendations:** HSAG recommends that Simply-C conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Simply-C implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.
⊖	**Weakness:** Simply-C's rates fell below the MY 2022 minimum performance targets for the following measure indicators: • *Initiation and Engagement of Substance Use Disorder (SUD) Treatment* (both indicators) **Recommendations:** HSAG recommends that Simply-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
⊖	**Weakness:** For both PIPs, opportunities for improvement were noted for Simply-C in the documentation of the statistical testing results and intervention evaluation data. **Recommendations:** HSAG recommends that Simply-C's PIP/QI team include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions. Simply-C must report complete intervention evaluation data as part of its PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission.
⊖	**Weakness:** The EDV comparative analysis revealed that the Agency reported the current billing provider NPI and attending provider NPI values on the PML Medicaid ID for the provider, while the plan submitted the NPI values from the PML at the time of encounter submission to the Agency. This appeared to be the root cause of discrepancy. **Recommendations:** HSAG recommends that Simply-C collaborate with the Agency to investigate the accuracy of the NPI information and understand the impact of PML updates on the differences observed.
⊖	**Weakness:** Simply-C's record omission rate for LTC institutional encounters was high, with a rate of 47.4 percent. The record omission rate for LTC professional encounters was high, with a rate of 11.5 percent, suggesting noticeable discrepancies at the record level when comparing the plan-submitted files to the Agency-submitted files. **Recommendations:** HSAG recommends that Simply-C work closely with the Agency to address any identified data discrepancies between the Agency- and plan-submitted encounters.

Sunshine-C

Strengths Related to Quality and/or Access and/or Timeliness	
⊕	Sunshine-C provided FARs that contained IS capability findings and Sunshine-C was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
⊕	Sunshine-C's rates met or exceeded the MY 2022 performance targets for the following measure indicators: • *Childhood Immunization Status—Combination 7* • *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD Medication—Initiation Phase* • *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD Medication—Continuation and Maintenance Phase* • *Asthma Medication Ratio—Total*
⊕	Sunshine-C's rates met or exceeded MY 2022 performance targets for both *LTSS Comprehensive Assessment and Update* measure indicators, both *LTSS Comprehensive Care Plan and Update* measure indicators, and *LTSS Shared Care Plan with Primary Care Practitioner (PCP)—Shared Care Plan with PCP*.
⊕	Sunshine-C reported achievement of statistically significant improvement over the baseline and significant programmatic improvement for the Administration of the Transportation Benefit PIP.
⊕	For the EDV, Sunshine-C's record omission rates were low for the LTC professional encounters. Sunshine-C's EDV results indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and institutional encounters.

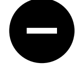
Weaknesses and Recommendations	
⊖	**Weakness:** Sunshine-C's rate fell below the MY 2022 minimum performance target for the *CIS—Combination 10* measure indicator. **Recommendations:** HSAG recommends that Sunshine-C identify best practices for ensuring children receive medically appropriate preventive influenza vaccinations. HSAG recommends that Sunshine-C review interventions that resulted in the plan meeting or exceeding the *CIS—Combination 7* performance target and determine whether similar interventions could be used to target the additional immunizations in the *CIS—Combination 10* measure indicator.
⊖	**Weakness:** Sunshine-C's rates fell below the MY 2022 minimum performance target for the *Prenatal and Postpartum Care* measure (both indicators). **Recommendations:** HSAG recommends that Sunshine-C consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care, when designing strategies to improve performance rates. In addition, HSAG recommends that Sunshine-C consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Sunshine-C implement appropriate interventions to reduce barriers to care.

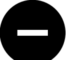
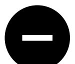
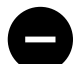
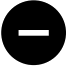
Weaknesses and Recommendations	
	**Weakness:** Sunshine-C's rates for the *Follow-Up After Emergency Department Visit for Mental Illness* measure and the *Follow-Up After Hospitalization for Mental Illness* measure fell below the MY 2022 minimum performance targets. **Recommendations:** To improve follow-up after members access the ED or are hospitalized for mental illness, HSAG recommends that Sunshine-C conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that Sunshine-C enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs. HSAG recommends that Sunshine-C partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
	**Weakness:** Sunshine-C's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure. **Recommendations:** HSAG recommends that Sunshine-C conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Sunshine-C implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	**Weakness:** Sunshine-C's rates also fell below the MY 2022 minimum performance targets for the following measure indicators: • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* • *Eye Exam for Patients With Diabetes* • *Hemoglobin A1c Control for Patients with Diabetes—HbA1c Poor Control (>9.0%)* • *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (1–17 Years)* • *Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total* **Recommendations:** HSAG recommends that Sunshine-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure. HSAG recommends that Sunshine-C review interventions that resulted in the plan meeting or exceeding the *CIS—Combination 7* performance target and determine if similar interventions could be used to target the additional immunizations in the *Immunizations for Adolescents—Combination 1* measure indicator.
	**Weakness:** Sunshine-C did not report statistically significant improvement over the baseline, significant clinical improvement, or significant programmatic improvement for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that Sunshine-C revisit the causal/barrier analysis using QI science tools to identify additional

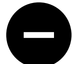
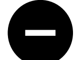
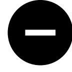
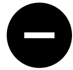
Weaknesses and Recommendations	
⊖	barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Sunshine-C ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that Sunshine-C consider seeking enrollee input to better understand enrollee-related barriers toward access to care.
⊖	**Weakness:** Sunshine-C's record omission and surplus rates for LTC institutional encounters were high, with rates of 7.2 percent and 24.8 percent, respectively, suggesting noticeable discrepancies at the record level when comparing the plan-submitted files to the Agency-submitted files. Sunshine-C's record surplus rate for LTC professional encounters was also high, with a rate of 12.6 percent. **Recommendations:** HSAG recommends that Sunshine-C work closely with the Agency to address any identified data discrepancies between the Agency- and plan-submitted encounters.

United-C

Strengths Related to Quality and/or Access and/or Timeliness	
	United-C provided FARs that contained IS capability findings and United-C was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
	United-C's rates met or exceeded the MY 2022 performance targets for the following measure indicators: • *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication* (both indicators) • *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three indicators) • *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* • *Asthma Medication Ratio—Total* • *Blood Pressure Control for Patients With Diabetes* • *Controlling High Blood Pressure* • *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
	United-C's rate met or exceeded MY 2022 performance targets for both *LTSS Comprehensive Assessment and Update* measure indicators and both *LTSS Comprehensive Care Plan and Update* measure indicators.
	For the EDV, United-C's record omission and record surplus rates were low (i.e., at or lower than 5.0 percent) for the LTC institutional and professional encounters. United-C's EDV results also indicated a high degree of element completeness and accuracy for most key data elements evaluated across both the LTC professional and LTC institutional encounters.

Weaknesses and Recommendations	
	**Weakness:** United-C's rate fell below the MY 2022 minimum performance target for the *CIS—Combination 10* measure indicator and did not meet the target for *CIS—Combination 3* or *CIS-Combination 7*. **Recommendations:** HSAG recommends that United-C identify best practices for ensuring children receive medically appropriate preventive influenza vaccinations. HSAG recommends that United-C consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, HSAG recommends that United-C implement appropriate interventions to improve the immunization rates.

Weaknesses and Recommendations	
	**Weakness:** United-C's rate fell below the MY 2022 minimum performance target for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator. **Recommendations:** HSAG recommends that United-C consider the health literacy of the population served, as well as their capacity to access prenatal care, when designing strategies to improve performance rates. In addition, HSAG recommends that United-C consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that United-C implement appropriate interventions to reduce barriers to care.
	**Weakness:** United-C's rate fell below the MY 2022 minimum performance target for the *Medical Assistance with Smoking and Tobacco Use Cessation—Discussing Cessation Strategies—Total (18+ Years)* measure indicator. **Recommendations:** HSAG recommends that United-C conduct further analysis or a focus study to determine why providers are not discussing and/or recommending cessation medications with their patients. Upon identification of a root cause, HSAG recommends that United-C implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation medication counseling.
	**Weakness:** United-C's rates for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total (6+ Years)* measure indicator and the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (6+ Years)* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (6+ Years)* measure indicators measure fell below the MY 2022 minimum performance targets. **Recommendations:** To improve follow-up after members access the ED or are hospitalized for mental illness, HSAG recommends that United-C conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that United-C enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs. HSAG recommends that United-C partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
	**Weakness:** United-C's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure. **Recommendations:** HSAG recommends that United-C conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that United-C implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.

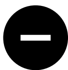
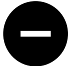
Weaknesses and Recommendations	
	**Weakness:** United-C's rates also fell below the MY 2022 minimum performance targets for the following measure indicators: • *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* • *Eye Exam for Patients With Diabetes* • *Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total* **Recommendations:** HSAG recommends that United-C conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
	**Weakness:** United-C did not meet the MY 2022 performance target for the *LTSS Shared Care Plan with Primary Care Practitioner—Shared Care Plan with PCP* measure. **Recommendations:** HSAG recommends that United-C evaluate opportunities to enhance care coordination with PCPs. HSAG recommends that United-C partner with its contracted providers to identify barriers that impede the plan from following recommended guidelines to share care plans with PCPs.
	**Weakness:** For the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP, opportunities for improvement were noted for United-C in the documentation of the statistical testing results and intervention evaluation data. **Recommendations:** HSAG recommends that United-C's PIP/QI team include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions. HSAG recommends that United-C report complete intervention evaluation data as part of its PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission.
	**Weakness:** United-C did not report statistically significant improvement over the baseline, significant clinical improvement, or significant programmatic improvement for either PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that United-C revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that United-C ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that United-C consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

Specialty Plans

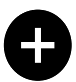
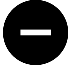
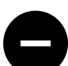
Children's Medical Services-S

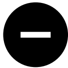
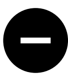
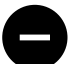
	Strengths Related to Quality and/or Access and/or Timeliness
⊕	CMS-S provided FARs that contained IS capability findings and CMS-S was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
⊕	CMS-S was one of the highest-performing plans in the Pediatric Care domain, with eight measure indicator rates meeting or exceeding the MY 2022 performance targets.
⊕	CMS-S' rates also met or exceeded the MY 2022 performance targets for the following: • *Asthma Medication Ratio—Total* • *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment—Total—Total (13+ Years)*
⊕	CMS-S reported achievement of significant programmatic improvement for the Administration of the Transportation Benefit PIP. For the Reducing Asthma Related PPEs for Pediatric Enrollees PIP, CMS-S sustained a statistically significant increase over the baseline for both performance indicators for the two consecutive remeasurement periods.

	Weaknesses and Recommendations
⊖	**Weakness:** CMS-S' rate fell below the MY 2022 minimum performance target for the *CIS—Combination 10* measure indicator. **Recommendations:** HSAG recommends that CMS-S identify best practices for ensuring children receive medically appropriate preventive influenza vaccinations. HSAG recommends that CMS-S review interventions that resulted in the plan meeting or exceeding the *CIS—Combination 3* and *CIS—Combination 7* performance target and determine whether similar interventions could be used to target the additional immunizations in the *CIS—Combination 10* measure indicator.
⊖	**Weakness:** CMS-S' rates fell below the MY 2022 minimum performance target for the *Prenatal and Postpartum Care* measure (both indicators). **Recommendations:** HSAG recommends that CMS-S consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care, when designing strategies to improve performance rates. In addition, HSAG recommends that CMS-S consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that CMS-S implement appropriate interventions to reduce barriers to care.
⊖	**Weakness:** CMS-S' rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure. **Recommendations:** HSAG recommends that CMS-S conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that CMS-S implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.

	Weaknesses and Recommendations
	**Weakness:** CMS-S' rates also fell below the MY 2022 minimum performance targets for the following measure indicators: • *Eye Exam for Patients With Diabetes* • *Hemoglobin A1c Control for Patients with Diabetes* (both indicators) • *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* • *Antidepressant Medication Management—Effective Continuation Phase Treatment* • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* • *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* **Recommendations:** HSAG recommends that CMS-S conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
	**Weakness:** CMS-S did not report any evidence of significant clinical or programmatic improvement for the Youth Transitions to Adult Care PIP and reported a decrease in the performance indicator rate over the baseline. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that CMS-S revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that CMS-S ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that CMS-S consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

Clear Health-S

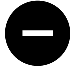
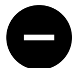
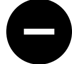
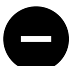
<table>
<tr><th colspan="2">Strengths Related to Quality and/or Access and/or Timeliness</th></tr>
<tr><td></td><td>Clear Health-S provided FARs that contained IS capability findings and Clear Health-S was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.</td></tr>
<tr><td> </td><td>Clear Health-S' rates met or exceeded the MY 2022 performance targets for the following measure indicators:
• Chlamydia Screening in Women—Total (16–24 Years)
• Hemoglobin A1c Control for Patients with Diabetes (both indicators)
• 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</td></tr>
<tr><td> </td><td>Clear Health-S' population was included in the comprehensive plan's PIP (Simply-C), which reported achievement of statistically significant improvement over the baseline and significant programmatic improvement for the Administration of the Transportation Benefit PIP. For the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP, Simply-C reported achievement of statistically significant improvement over baseline for one of three performance indicators, as well as significant clinical improvement and significant programmatic improvement.</td></tr>
<tr><th colspan="2">Weaknesses and Recommendations</th></tr>
<tr><td></td><td>Weakness: Clear Health-S was one of the lowest-performing plans in the Pediatric Care domain, with seven measure indicator rates falling below the MY 2022 minimum performance targets.
Recommendations: HSAG recommends that Clear Health-S conduct a root cause analysis or focus study to determine barriers to pediatric members receiving the services related to each measure that fell below the performance target. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.</td></tr>
<tr><td></td><td>Weakness: Clear Health-S' rates fell below the MY 2022 minimum performance target for the Prenatal and Postpartum Care measure (both indicators).
Recommendations: HSAG recommends that Clear Health-S consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care, when designing strategies to improve performance rates. In addition, HSAG recommends that Clear Health-S consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Clear Health-S implement appropriate interventions to reduce barriers to care.</td></tr>
</table>

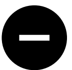
Weaknesses and Recommendations	
	**Weakness:** Clear Health-S was among the lowest-performing plans in the Behavioral Health domain, with seven measure indicator rates falling below the MY 2022 minimum performance targets, including the *Follow-Up After Emergency Department Visit for Mental Illness* measure and the *Follow-Up After Hospitalization for Mental Illness* measure. **Recommendations:** To improve follow-up after members access the ED or are hospitalized for mental illness, HSAG recommends that Clear Health-S conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that Clear Health-S enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs. HSAG recommends that Clear Health-S partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
	**Weakness:** Clear Health-S' rates also fell below the MY 2022 minimum performance targets for the following measure indicators: • *Asthma Medication Ratio—Total* • *Eye Exam for Patients With Diabetes* • *Kidney Health Evaluation for Patients with Diabetes—Ages 65–74 Years* • *Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total* **Recommendations:** HSAG recommends that Clear Health-S conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
	**Weakness:** For both PIPs, opportunities for improvement were noted for Clear Health-S (and Simply-C) in the documentation of the statistical testing results and intervention evaluation data. **Recommendations:** HSAG recommends that the PIP/QI teams for Clear Health-S (and Simply-C) include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions. HSAG recommends that Clear Health-S (and Simply-C) report complete intervention evaluation data as part of their PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission.

Molina-S

Strengths Related to Quality and/or Access and/or Timeliness	
⊕	Molina-S provided FARs that contained IS capability findings and Molina-S was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
⊕	Molina-S' rates met or exceeded the MY 2022 performance target for the following measure indicators: • *Chlamydia Screening in Women—Total (16-24 Years)*
⊕	Molina-S' population was included in the comprehensive plan's PIP (Molina-C), which reported achievement of significant programmatic improvement for the Administration of the Transportation Benefit PIP and achievement of statistically significant improvement over the baseline for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP for one of three performance indicators.

Weaknesses and Recommendations	
⊖	**Weakness:** Molina-S was one of the lowest-performing plans in the Pediatric Care domain, with six measure indicator rates falling below the MY 2022 minimum performance targets. **Recommendations:** HSAG recommends that Molina-S conduct a root cause analysis or focus study to determine barriers to pediatric members receiving the services related to each measure that fell below the performance target. Molina-S should consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Molina-S implement appropriate interventions to improve the performance related to each measure.
⊖	**Weakness:** Molina-S was one of the lowest-performing plans in the Women's Care domain, with four out of five measure indicator rates falling below the MY 2022 minimum performance targets. **Recommendations:** HSAG recommends that Molina-S conduct a root cause analysis or focus study to determine barriers to women receiving the services related to each measure that fell below the performance target. Molina-S should consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Molina-S implement appropriate interventions to improve the performance related to each measure.
⊖	**Weakness:** Molina-S was one of the lowest-performing plans in the Living with Illness domain, with five measure indicator rates falling below the MY 2022 minimum performance targets. **Recommendations:** HSAG recommends that Molina-S conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure that fell below the performance target. Molina-S should consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Molina-S implement appropriate interventions to improve the performance related to each measure.

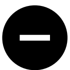
Weaknesses and Recommendations	
	**Weakness:** Molina-S was among the lowest-performing plans in the Behavioral Health domain, with eight measure indicator rates falling below the MY 2022 minimum performance targets, including the *Follow-Up After Emergency Department Visit for Mental Illness* measure and the *Follow-Up After Hospitalization for Mental Illness* measure. **Recommendations:** To improve follow-up after members access the ED or are hospitalized for mental illness, HSAG recommends that Molina-S conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that Molina-S enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs. HSAG recommends that Molina-S partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
	**Weakness:** Molina-S' rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure. **Recommendations:** HSAG recommends that Molina-S conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Molina-S implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	**Weakness:** Molina-S' rate also fell below the MY 2022 minimum performance target for the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total* measure. **Recommendations:** HSAG recommends that Molina-S conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
	**Weakness:** For both PIPs, opportunities for improvement were noted for Molina-S (and Molina-C) in the documentation of the statistical testing results and intervention evaluation data. **Recommendations:** HSAG recommends that the PIP/QI teams of Molina-S (and Molina-C) include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions. HSAG also recommends that Molina-S (and Molina-C) report complete intervention evaluation data as part of their PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission.

Weaknesses and Recommendations	
	**Weakness:** Molina-S (and Molina-C) did not report achievement of statistically significant improvement over the baseline or significant clinical improvement or programmatic improvement for Administration of the Transportation Benefit PIP. Molina-S (and Molina-C) did not report significant clinical or programmatic improvement for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that Molina-S (and Molina-C) revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Molina-S (and Molina-C) ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that Molina-S (and Molina-C) consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

Sunshine-S-CW

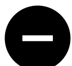
Strengths Related to Quality and/or Access and/or Timeliness	
+	Sunshine-S-CW provided FARs that contained IS capability findings and Sunshine-S-CW was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
+	Sunshine-S-CW was one of the highest-performing plans in the Pediatric Care domain, with 11 measure indicator rates meeting or exceeding the MY 2022 performance targets.
+	Sunshine-S-CW's rates also met or exceeded the MY 2022 performance targets for the following measure indicator: • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total*
+	Sunshine-S-CW's population was included in the comprehensive plan's PIP (Sunshine-C), which reported achievement of statistically significant improvement over the baseline and significant programmatic improvement for the *Administration of the Transportation Benefit* PIP.

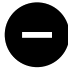
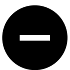
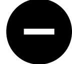
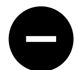
Weaknesses and Recommendations	
−	**Weakness:** Sunshine-S-CW's rate fell below the MY 2022 minimum performance target for the *Prenatal and Postpartum Care* measure (both indicators).
	Recommendations: HSAG recommends that Sunshine-S-CW consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care, when designing strategies to improve performance rates. In addition, HSAG recommends that Sunshine-S-CW consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Sunshine-S-CW implement appropriate interventions to reduce barriers to care.
−	**Weakness:** Sunshine-S-CW was among the lowest-performing plans in the Living with Illness domain, with nine measure indicator rates falling below the MY 2022 minimum performance targets, including the *Medical Assistance with Smoking and Tobacco Use Cessation* measure.
	Recommendations: HSAG recommends that Sunshine-S-CW conduct further analysis or a focus study to determine why providers are not discussing and/or recommending cessation medications with their patients. Upon identification of a root cause, HSAG recommends that Sunshine-S-CW implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation medication counseling.
−	**Weakness:** Sunshine-S-CW's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure.
	Recommendations: HSAG recommends that Sunshine-S-CW conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Sunshine-S-CW implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Weaknesses and Recommendations	
	**Weakness:** Sunshine-S-CW (and Sunshine-C) did not report statistically significant improvement over the baseline, significant clinical improvement, or significant programmatic improvement for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that Sunshine-S-CW (and Sunshine-C) revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Sunshine-S-CW (and Sunshine-C) ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that Sunshine-S-CW (and Sunshine-C) consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

Sunshine-S-SMI

Strengths Related to Quality and/or Access and/or Timeliness	
+	Sunshine-S-SMI provided FARs that contained IS capability findings and Sunshine-S-SMI was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
+	Sunshine-S-SMI also met or exceeded the MY 2022 performance targets for the following measure indicators: • *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication* (both indicators) • *Chlamydia Screening in Women—Total (16–24 Years)*
+	Sunshine-S-SMI's population was included in the comprehensive plan's PIP (Sunshine-C), which reported achievement of statistically significant improvement over the baseline and significant programmatic improvement for the Administration of the Transportation Benefit PIP.

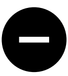
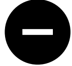
Weaknesses and Recommendations	
−	**Weakness:** Sunshine-S-SMI's rate fell below the MY 2022 minimum performance target for the *Prenatal and Postpartum Care* measure (both indicators).
	Recommendations: HSAG recommends that Sunshine-S-SMI consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care, when designing strategies to improve performance rates. In addition, HSAG recommends that Sunshine-S-SMI consider whether there are disparities within the plans' populations that contributed to lower access to care. Upon identification of a root cause, HSAG recommends that Sunshine-S-SMI implement appropriate interventions to reduce barriers to care.
	**Weakness:** Sunshine-S-SMI was among the lowest-performing plans in the Living with Illness domain, with six measure indicator rates falling below the MY 2022 minimum performance targets, including the *Medical Assistance with Smoking and Tobacco Use Cessation* measure.
	Recommendations: HSAG recommends that Sunshine-S-SMI conduct further analysis or a focus study to determine why providers are not discussing and/or recommending cessation medications with their patients. Upon identification of a root cause, HSAG recommends that Sunshine-S-SMI implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation medication counseling.

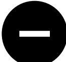
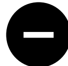
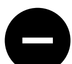
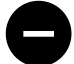
<table>
<tr><th colspan="2">Weaknesses and Recommendations</th></tr>
<tr><td rowspan="2"></td><td>Weakness: Sunshine-S-SMI had six measure indicator rates in the Behavioral Health domain fall below the MY 2022 minimum performance targets, including the Follow-Up After Emergency Department Visit for Mental Illness measure and the Follow-Up After Hospitalization for Mental Illness measure.</td></tr>
<tr><td>Recommendations: To improve follow-up after members access the ED or are hospitalized for mental illness, HSAG recommends that Sunshine-S-SMI conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that Sunshine-S-SMI enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs. HSAG recommends that Sunshine-S-SMI partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.</td></tr>
<tr><td></td><td>Weakness: Sunshine-S-SMI’s rates also fell below the MY 2022 minimum performance targets for the following measure indicators:
• Child and Adolescent Well-Care Visits—Total (3–21 Years)
• Cervical Cancer Screening—Cervical Cancer Screening
• Ambulatory Care (per 1,000 Member Months)—Emergency Department Visits—Total
• Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total
Recommendations: HSAG recommends that Sunshine-S-SMI conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.</td></tr>
<tr><td></td><td>Weakness: Sunshine-S-SMI’s rate fell below the MY 2022 minimum performance target for the Adults’ Access to Preventive/Ambulatory Health Services measure.
Recommendations: HSAG recommends that Sunshine-S-SMI conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Sunshine-S-SMI implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.</td></tr>
<tr><td></td><td>Weakness: Sunshine-S-SMI (and Sunshine-C) did not report statistically significant improvement over the baseline, significant clinical improvement, or significant programmatic improvement for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP.
Recommendations: For the PIPs with unsuccessful outcomes, HSAG recommends that Sunshine-S-SMI (and Sunshine-C) revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Sunshine-S-SMI (and Sunshine-C) ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that Sunshine-S-SMI (and Sunshine-C) consider seeking enrollee input to better understand enrollee-related barriers toward access to care.</td></tr>
</table>

Managed Medical Assistance Plans

AmeriHealth-M

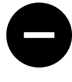
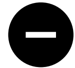
	Strengths Related to Quality and/or Access and/or Timeliness
	AmeriHealth-M provided FARs that contained IS capability findings and AmeriHealth-M was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
	AmeriHealth-M was the highest-performing plan in the Pediatric Care domain, with 15 measure indicator rates meeting or exceeding the MY 2022 performance targets.
	AmeriHealth-M's rates also met or exceeded the performance targets for the following measure indicators: • *Chlamydia Screening in Women—Total (16–24 Years)* • *Asthma Medication Ratio—Total* • *Kidney Health Evaluation for Patients with Diabetes* (all three indicators)
	AmeriHealth-M reported achievement of significant programmatic improvement for the Administration of the Transportation Benefit PIP.

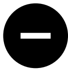
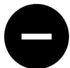
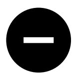
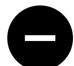
	Weaknesses and Recommendations
	**Weakness:** AmeriHealth-M's rates fell below the MY 2022 minimum performance target for the *Medical Assistance with Smoking and Tobacco Use Cessation* measure (for two of three indicators).
	Recommendations: HSAG recommends that AmeriHealth-M conduct further analysis or a focus study to determine why providers are not discussing and/or recommending cessation medications with their patients. Upon identification of a root cause, HSAG recommends that AmeriHealth-M implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation medication counseling.
	**Weakness:** AmeriHealth-M's rates for both indicators of the *Follow-Up After Emergency Department Visit for Mental Illness* measure fell below the MY 2022 minimum performance targets.
	Recommendations: To improve follow-up after members access the ED for mental illness, HSAG recommends that AmeriHealth-M conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that AmeriHealth-M enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs. HSAG recommends that AmeriHealth-M partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after ED access for mental illness.

Weaknesses and Recommendations	
	**Weakness:** AmeriHealth-M's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure.
	Recommendations: HSAG recommends that AmeriHealth-M conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that AmeriHealth-M implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	**Weakness:** AmeriHealth-M's rate fell below the MY 2022 minimum performance targets for the following measure indicators: • *Blood Pressure Control for Patients With Diabetes* • *Eye Exam for Patients With Diabetes* • *Antidepressant Medication Management* (both indicators) • *Follow-Up After Emergency Department Visit for Mental Illness* • *Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Engagement of SUD Treatment—Total—Total (13+ Years)* **Recommendations:** HSAG recommends that AmeriHealth-M conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
	**Weakness:** For both PIPs, opportunities for improvement were noted for AmeriHealth-M in the documentation of the statistical testing results and intervention evaluation data.
	Recommendations: HSAG recommends that AmeriHealth-M's PIP/QI team include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions. HSAG also recommends that AmeriHealth-M report complete intervention evaluation data as part of its PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission.
	**Weakness:** AmeriHealth-M did not report achievement of statistically significant improvement over the baseline or significant clinical improvement for *Administration of the Transportation Benefit* PIP. AmeriHealth-M did not report any significant improvement in outcomes for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that AmeriHealth-M revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that AmeriHealth-M ensure that data-driven decisions are made to revise the interventions to realize improvement. HSAG also recommends that AmeriHealth-M consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

Community Care Plan-M

	Strengths Related to Quality and/or Access and/or Timeliness
+	Community Care Plan-M provided FARs that contained IS capability findings and Community Care Plan-M was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
+	Community Care Plan-M was one of the highest-performing plans in the Pediatric Care domain, with eight measure indicator rates meeting or exceeding the MY 2022 performance targets.
+	Community Care Plan-M's rate also met or exceeded the MY 2022 performance targets for the following measure indicators: • *Chlamydia Screening in Women—Total (16–24 Years)* • *Kidney Health Evaluation for Patients with Diabetes* (all four indicators) • *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (all three indicators)
+	Community Care Plan-M reported achievement of significant clinical and programmatic improvement for both PIPs.

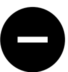
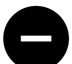
	Weaknesses and Recommendations
	**Weakness:** Community Care Plan-M's rate fell below the MY 2022 minimum performance target for the *CIS—Combination 10* measure indicator and did not meet the target for *CIS-Combination 3* or *CIS-Combination 7*.
	Recommendations: HSAG recommends that Community Care Plan-M identify best practices for ensuring children receive medically appropriate preventive influenza vaccinations. Community Care Plan-M should consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause HSAG recommends that Community Care Plan-M implement appropriate interventions to improve the immunization rates.
	**Weakness:** Community Care Plan-M's rates for both indicators of the *Follow-Up After Emergency Department Visit for Mental Illness* measure fell below the MY 2022 minimum performance targets.
	Recommendations: To improve follow-up after members access the ED for mental illness, HSAG recommends that Community Care Plan-M conduct an SDOH analysis to identify any health equity gaps to establish potential performance improvement strategies. Ensuring consistent data sharing about admissions and discharges will assist in data analysis to provide potential strategies for improvement. Additionally, HSAG recommends that Community Care Plan-M enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs. HSAG recommends that Community Care Plan-M partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after ED access for mental illness.

Weaknesses and Recommendations	
	**Weakness:** Community Care Plan-M's rate fell below the MY 2022 minimum performance target for the *Adults' Access to Preventive/Ambulatory Health Services* measure.
	Recommendations: HSAG recommends that Community Care Plan-M conduct a root cause analysis or focus study to determine why members did not consistently access preventive and ambulatory services. Upon identification of a root cause, HSAG recommends that Community Care Plan-M implement appropriate interventions to improve performance. HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	**Weakness:** Community Care Plan-M's rates fell below the MY 2022 minimum performance targets for the following measure indicators: • *Blood Pressure Control for Patients With Diabetes* • *Medical Assistance with Smoking and Tobacco Use Cessation* (two of three indicators) • *Adherence to Antipsychotic Medications for Individuals With Schizophrenia—Adherence to Antipsychotic Medications for Individuals With Schizophrenia* • *Initiation and Engagement of Substance Use Disorder (SUD) Treatment* (both indicators) • *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (1–17 Years)* **Recommendations:** HSAG recommends that Community Care Plan-M conduct a root cause analysis or focus study to determine barriers to members receiving the services related to each measure. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve the performance related to each measure.
	**Weakness:** For both PIPs, opportunities for improvement were noted for Community Care Plan-M in the documentation of the statistical testing results and intervention evaluation data.
	Recommendations: HSAG recommends that Community Care Plan-M's PIP/QI team include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions. HSAG recommends that Community Care Plan-M report complete intervention evaluation data as part of its PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission.
	**Weakness:** Community Care Plan-M did not report achievement of statistically significant improvement over the baseline for either PIP. **Recommendations:** For PIPs with unsuccessful outcomes, HSAG recommends that Community Care Plan-M revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Community Care Plan-M ensure that data-driven decisions are made to revise the interventions to realize improvement. Community Care Plan-M should consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

Long-Term Care Plus Plan

Florida Community Care-L

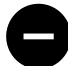
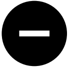
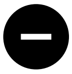
Strengths Related to Quality and/or Access and/or Timeliness	
⊕	Florida Community Care-L provided FARs that contained IS capability findings and Florida Community Care-L was fully compliant with NCQA HEDIS Compliance Audit IS standards 1.0, 2.0, 3.0, 4.0, 5.0, 6.0, and 7.0.
⊕	Florida Community Care-L's rates met or exceeded the MY 2022 performance targets for both *LTSS Comprehensive Assessment and Update* measure indicators, both *LTSS Comprehensive Care Plan and Update* measure indicators, and *LTSS Shared Care Plan with Primary Care Practitioner (PCP)—Shared Care Plan with PCP*.
⊕	Florida Community Care-L reported achievement of significant programmatic improvement for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP.

Weaknesses and Recommendations	
	**Weakness:** For the Administration of the Transportation Benefit PIP, opportunities for improvement were noted for Florida Community Care-L in the documentation of the statistical testing results and intervention evaluation data. **Recommendations:** HSAG recommends that Florida Community Care-L's PIP/QI team include one or more data analysts. Data mining and analysis are crucial components to justify topics and evaluate interventions. HSAG also recommends that Florida Community Care-L report complete intervention evaluation data as part of its PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission.
	**Weakness:** Florida Community Care-L did not report achievement of any significant improvement in outcomes for the Administration of the Transportation Benefit PIP. Florida Community Care-L did not report achievement of statistically significant improvement over the baseline or significant clinical improvement for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that Florida Community Care-L revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Florida Community Care-L ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that Florida Community Care-L consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

Dental Plans

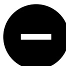
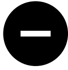
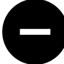
DentaQuest-D

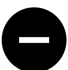
	Strengths Related to Quality and/or Access and/or Timeliness
	DentaQuest-D reported achievement of statistically significant improvement over the baseline and significant clinical improvement for the Preventive Dental Services for Children PIP.

	Weaknesses and Recommendations
	**Weakness:** DentaQuest-D fell below the MY 2022 plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator. **Recommendations:** HSAG recommends that DentaQuest-D conduct an analysis of SDOH to identify any disparities preventing members from receiving dental treatment services. Upon identification of any health disparities, HSAG recommends that DentaQuest-D implement appropriate interventions to access to care. If barriers to care are impacting the rates, HSAG recommends that DentaQuest-D also evaluate its networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends that DentaQuest-D work with providers to offer extended office hours/weekend availability or mobile clinics for members who may have barriers such as work or transportation.
	**Weakness:** Four statewide rates, *Topical Fluoride for Children Dental or Oral Health Services—Total (1–20 Years)* and *Follow-Up after Dental Related Emergency Department Visits —Total, Sealant Receipt on Permanent First Molars—At Least One Sealant,* and *Sealant Receipt on Permanent Molars—All Four Permanent First Molars* measure indicators declined by more than 3 percentage points in MY 2022 relative to MY 2021. **Recommendations:** HSAG recommends that DentaQuest-D conduct an analysis to identify any disparities preventing members from receiving dental treatment services. Upon identification of any disparities in the plan's population, HSAG recommends that DentaQuest-D implement appropriate interventions to access to care. If barriers to care are impacting the rates, HSAG recommends that DentaQuest-D also evaluate its networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends that the plan ensure that dental providers offer extended office hours/weekend availability or mobile clinics for members who may have barriers such as work or transportation.
	**Weakness:** DentaQuest-D did not report achievement of any significant programmatic improvement for the Preventive Dental Services for Children PIP. For the Coordination of Transportation Services With the SMMC Plans PIP, DentaQuest-D did not achieve any significant improvement. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that DentaQuest-D revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that DentaQuest-D ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that DentaQuest-D consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

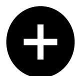
Liberty-D

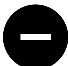
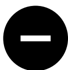
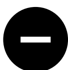
Strengths Related to Quality and/or Access and/or Timeliness	
	Liberty-D reported achievement of statistically significant improvement over the baseline and significant clinical and programmatic improvement for the Preventive Dental Services for Children PIP. For the Coordination of Transportation Services With the SMMC Plans PIP, Liberty-D reported achievement of statistically significant improvement over the baseline and significant programmatic improvement.

Weaknesses and Recommendations	
	**Weakness:** Liberty-D fell below the MY 2022 plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator.
	Recommendations: HSAG recommends that Liberty-D conduct an analysis of SDOH to identify any disparities preventing members from receiving dental treatment services. Upon identification of any disparities, HSAG recommends that Liberty-D implement appropriate interventions to access to care. If barriers to care are impacting the rates, HSAG recommends that Liberty-D also evaluate its networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends that Liberty-D work with providers to offer extended office hours/weekend availability or mobile clinics for members who may have barriers such as work or transportation.
	**Weakness:** Four statewide rates, *Topical Fluoride for Children Dental or Oral Health Services—Total (1–20 Years)* and *Follow-Up after Dental Related Emergency Department Visits —Total, Sealant Receipt on Permanent First Molars—At Least One Sealant,* and *Sealant Receipt on Permanent Molars—All Four Permanent First Molars* measure indicators declined by more than 3 percentage points in MY 2022 relative to MY 2021.
	Recommendations: HSAG recommends that Liberty-D conduct an analysis of SDOH to identify any disparities preventing members from receiving dental treatment services. Upon identification of any health disparities in the plan's population, HSAG recommends that Liberty-D implement appropriate interventions to access to care. If barriers to care are impacting the rates, HSAG recommends that Liberty-D also evaluate its networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends that the plan ensure that providers offer extended office hours/weekend availability or mobile clinics for members who may have barriers such as work or transportation.
	**Weakness:** Liberty-D had opportunities for improvement in reporting accurate data and documenting complete intervention evaluation data. **Recommendations:** HSAG recommends that Liberty-D report complete intervention evaluation data as part of its PIP submissions, including any real-time, relevant data/information up until the day before the PIP submission. Quantitative intervention evaluation data collection is preferred. Achievement of significant programmatic and significant clinical improvement must be supported by appropriate intervention evaluation data demonstrating intervention effectiveness.

Weaknesses and Recommendations	
	**Weakness:** Liberty-D did not report achievement of any significant clinical improvement for the Coordination of Transportation Services With the SMMC Plans PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that Liberty-D revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that Liberty-D ensure that data-driven decisions are made to revise the interventions to realize improvement. In addition, HSAG recommends that Liberty-D consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

MCNA-D

Strengths Related to Quality and/or Access and/or Timeliness	
	MCNA-D reported achievement of significant clinical improvement for both PIPs.

Weaknesses and Recommendations	
	**Weakness:** MCNA-D fell below the MY 2022 plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator.
	Recommendations: HSAG recommends that MCNA-D conduct an analysis of SDOH to identify any disparities preventing members from receiving dental treatment services. Upon identification of any health disparities, HSAG recommends that MCNA-D implement appropriate interventions to access to care. If barriers to care are impacting the rates, HSAG recommends that MCNA-D also evaluate its networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends that MCNA-D work with providers to offer extended office hours/weekend availability or mobile clinics for members who may have barriers such as work or transportation.
	**Weakness:** Four statewide rates, *Topical Fluoride for Children Dental or Oral Health Services—Total (1–20 Years)* and *Follow-Up after Dental Related Emergency Department Visits —Total, Sealant Receipt on Permanent First Molars—At Least One Sealant,* and *Sealant Receipt on Permanent Molars—All Four Permanent First Molars* measure indicators declined by more than 3 percentage points in MY 2022 relative to MY 2021.
	Recommendations: HSAG recommends that MCNA-D conduct an analysis of SDOH to identify any disparities preventing members from receiving dental treatment services. Upon identification of any health disparities in the plan's population, HSAG recommends that MCNA-D implement appropriate interventions to access to care. If barriers to care are impacting the rates, HSAG recommends that MCNA-D also evaluate its networks to ensure enough providers are available for members, and ensure those providers have appropriate appointment availability. Additionally, HSAG recommends that the plan ensure that providers offer extended office hours/weekend availability or mobile clinics for members who may have barriers such as work or transportation.
	**Weakness:** MCNA-D did not report achievement of statistically significant improvement over the baseline or significant programmatic improvement for either PIP. **Recommendations:** For the PIPs with unsuccessful outcomes, HSAG recommends that MCNA-D revisit the causal/barrier analysis using QI science tools to identify additional barriers and implement new interventions. If continuing with the same interventions, HSAG recommends that MCNA-D ensure that data-driven decisions are made to revise the interventions to realize improvement. HSAG recommends that MCNA-D consider seeking enrollee input to better understand enrollee-related barriers toward access to care.

Appendix D. PIP High-Level Review Results

The plans submitted two PIPs and the dental plans submitted one PIP to HSAG for a high-level review. It is the Agency's expectation that the health and dental plans address HSAG's feedback prior to the next annual submission.

In SFY 2022–2023, the health and dental plans had progressed to reporting remeasurement data. The Agency provided statewide Remeasurement 3 rates by region and population served (i.e., specialty plans) for each high-level review PIP to the health and dental plans. HSAG reviewed the PIP indicators' rates and assessed whether the plans achieved the contractually agreed upon goals.

Table D-1 displays the regions wherein the plans met the goals for the Improving Birth Outcomes and Reducing PPEs PIP performance indicators.

Table D-1—Results for the High-Level Review PIPs

Plan Name	Regions Served	Regions Where Improving Birth Outcomes PIP Goal Was Met			Regions Where Reducing PPEs PIP Goal Was Met		
		Primary C-Section Rate	Preterm Delivery Rate	NAS per 1,000 Live Births	PPAs per 1,000 Enrollee Months	PPRs per 1,000 Hospital Admissions	PPVs per 1,000 Enrollee Months
Aetna-C	*6, 7, 11*	None	11	6, 7	None	None	All
AmeriHealth-M	*9, 11*	None	None	9	All	All	All
Community Care Plan-M	*10*	None	None	10	All	All	All
Florida Community Care-L	*All regions*	NA	NA	NA	None	2	All
Humana-C	*All regions*	None	5, 7, 9, 11	1, 3, 4, 7, 8, 9, 10	2, 3, 4, 7, 8, 9, 10, 11	1, 2, 6, 9	All
Molina-C	*8, 11*	None	11	8	8	None	All
Molina-S	*4, 5, 7*	4,5	7	NA	All	4,5	7
Simply-C***	*1, 2, 5, 6, 7, 9, 10, 11*	2	None	1, 2, 5, 6, 7, 10	All	1, 2, 7, 9, 10, 11	All
ClearHealth-S***	*All regions*	NA	5, 10	NA	All	1, 4, 6	1, 4, 5, 6, 7, 8
Sunshine-C	*All regions*	4, 7	None	1	2, 3, 4, 6, 7, 8	1, 2, 4	All
Sunshine-S-CW	*All regions*	2,4,5,6,11	1, 4, 5, 6, 8, 9, 11	NA	All	None	All

Plan Name	Regions Served	Regions Where Improving Birth Outcomes PIP Goal Was Met			Regions Where Reducing PPEs PIP Goal Was Met		
		Primary C-Section Rate	Preterm Delivery Rate	NAS per 1,000 Live Births	PPAs per 1,000 Enrollee Months	PPRs per 1,000 Hospital Admissions	PPVs per 1,000 Enrollee Months
Sunshine-S-SMI	*All regions*	1, 2, 3, 5, 6, 7, 9, 10, 11	None	NA	1, 2, 3, 4, 5, 6, 8, 9, 10, 11	1, 4	2, 4, 6, 7, 8
United-C	*3, 4, 6, 11*	3, 4	4, 11	3, 4, 6	4, 11	4, 6, 11	All

* The results in the table were determined met/not met based on the performance indicator(s) rates reported by the plans in the PIP submission.

** Florida Community Care-L reported CY 2019 and CY 2020 data. The plan calculated one cumulative rate for all regions served and indicated it achieved approval from the Agency for the revised measurement periods and the data reporting process.

*** Simply-C and Clear Health-S did not provide goals and did not include a comparison with goals in the PIP submission.

NA: Not applicable because the PIP was not initiated by the plan.

NR: The data were not reported in the PIP Submission Form.

For the Improving Birth Outcomes PIP, none of the plans met all the goals for the three PIP performance indicators.

For the Reducing PPEs PIP, AmeriHealth-M and Community Care Plan-M met all the goals for the three PIP performance indicators. All plans except Molina-S, Clear Health-S, and Sunshine-S-SMI met the goals for reducing the PPVs in all regions served by the plans.

For the Reducing Potentially Preventable Dental-Related Emergency Department Visits PIP, the three dental plans provided statewide remeasurement rates. All three plans met the goal for reducing the preventable dental ED visit rate.

The PIP performance indicator rates as reported in the PIP submissions are shown in the tables below.

Table D-2—Performance Indicator Rates by Region and Population Served for the Improving Birth Outcomes PIP

(green)	The remeasurement rates are indicated with a green background color when the goal was met.
(orange)	The remeasurement rates are indicated with an orange background color when the goal was not met
The first rate presented for each plan represents the baseline rate.	

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Primary C-Section Rate												
Aetna-C	CY 2016						16.39%	17.10%				26.43%
	10/01/2020–09/30/2021						19.03%	17.70%				25.68%
AmeriHealth-M	CY 2016									18.00%		26.43%
	10/01/2020–09/30/2021									21.64%		27.33%
Community Care Plan-M	CY 2016										19.11%	
	10/01/2020–09/30/2021										25.03%	
Humana-C	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2020–09/30/2021	28.47%	37.13%	37.10%	35.74%	37.00%	37.39%	40.70%	38.81%	32.00%	37.10%	36.05%
Molina-C	CY 2016								15.76%			26.43%
	10/01/2020–09/30/2021								22.03%			34.36%
Molina-S	CY 2016				17.34%	16.87%		17.10%				
	10/01/2020–09/30/2021				15.63%	5.00%		18.75%				

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Simply-C	CY 2016	16.90%	18.45%			16.87%	16.39%	17.10%		18.00%	19.11%	26.43%
	10/01/2020–09/30/2021	19.39%	16.58%			20.50%	19.58%	21.59%		25.58%	24.52%	33.53%
Clear Health-S	CY 2016	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	10/01/2020–09/30/2021	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sunshine-C	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2020–09/30/2021	17.12%	19.72%	17.31%	15.47%	19.25%	16.39%	15.70%	18.02%	18.34%	21.23%	25.23%
Sunshine-S-CW	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2020–09/30/2021	50.00%	0.00%	30.00%	6.25%	0.00%	11.76%	33.33%	50.00%	38.46%	20.00%	12.50%
Sunshine-S-SMI	CY 2016	16.90%	18.45%	17.67%	17.34%	16.87%	16.39%	17.10%	15.76%	18.00%	19.11%	26.43%
	10/01/2020–09/30/2021	13.03%	14.36%	15.28%	17.03%	10.93%	12.38%	12.12%	16.70%	12.04%	15.67%	20.36%
United-C	CY 2016			17.67%	17.34%		16.39%					26.43%
	10/01/2020–09/30/2021			14.18%	15.58%		16.69%					28.64%
Pre-Term Delivery Rate												
Aetna-C	CY 2016						9.31%	9.56%				9.33%
	10/01/2020–09/30/2021						10.57%	9.53%				8.75%
AmeriHealth-M	CY 2016									8.65%		9.33%
	10/01/2020–09/30/2021									10.15%		10.87%

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Community Care Plan-M	CY 2016										11.41%	
	10/01/2020–09/30/2021										11.95%	
Humana-C	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2020–09/30/2021	13.59%	12.07%	11.37%	11.61%	8.30%	9.96%	8.92%	9.14%	7.28%	12.43%	7.72%
Molina-C	CY 2016								8.62%			9.33%
	10/01/2020–09/30/2021								11.13%			7.14%
Molina-S	CY 2016				10.88%	9.53%		9.56%				
	10/01/2020–09/30/2021				12.50%	15.00%		3.13%				
Simply-C	CY 2016	10.85%	9.73%			9.53%	9.31%	9.56%		8.65%	11.41%	9.33%
	10/01/2020–09/30/2021	12.47%	10.05%			9.54%	9.46%	9.87%		9.77%	11.44%	9.40%
Clear Health-S	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2020–09/30/2021	11.11%	36.36%	9.68%	17.39%	5.56%	20.51%	21.21%	12.50%	20.00%	5.88%	9.76%
Sunshine-C	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2020–09/30/2021	14.23%	11.03%	10.08%	10.88%	9.62%	10.77%	10.67%	9.56%	10.02%	13.66%	9.10%
Sunshine-S-CW	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2020–09/30/2021	0.00%	25.00%	20.00%	6.25%	0.00%	5.88%	11.11%	0.00%	0.00%	20.00%	0.00%

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Sunshine-S-SMI	CY 2016	10.85%	9.73%	10.21%	10.88%	9.53%	9.31%	9.56%	8.62%	8.65%	11.41%	9.33%
	10/01/2020–09/30/2021	19.54%	10.77%	12.68%	13.10%	16.08%	12.55%	13.33%	12.02%	12.61%	15.30%	16.41%
United-C	CY 2016			10.21%	10.88%		9.31%					9.33%
	10/01/2020–09/30/2021			10.20%	10.53%		10.78%					9.01%
NAS per 1,000 Live Births												
Aetna-C	CY 2016						13.5	17				1.6
	10/01/2020–09/30/2021						11.35	7.12				2.04
AmeriHealth-M	CY 2016									12.9		1.6
	10/01/2020–09/30/2021									11.82		3.23
Community Care Plan-M	CY 2016										10.4	
	10/01/2020–09/30/2021										3.52	
Humana-C	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/01/2020–09/30/2021	25.41	17.24	17.87	19.38	59.32	14.13	11.18	21.98	11.74	8.71	2.24
Molina-C	CY 2016								27.1			1.6
	10/01/2020–09/30/2021								13.31			2.26
Molina-S	CY 2016				42.3	44.1		17				
	10/01/2020–09/30/2021				NA	NA		NA				

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Simply-C	CY 2016	28.9	17.4			44.1	13.5	17		12.9	10.4	1.6
	10/01/2020–09/30/2021	22.57	15.35			30.66	8.97	12.74		13.26	5.79	2.35
Clear Health-S	CY 2016	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	10/01/2020–09/30/2021	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sunshine-C	CY 2016	28.9	17.4	30.7	42.3	44.1	13.5	17	27.1	12.9	10.4	1.6
	10/01/2020–09/30/2021	24.04	34.62	37.87	45.27	84.89	28.73	32.44	71.26	27.10	12.49	5.28
Sunshine-S-CW	CY 2016	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	10/01/2020–09/30/2021	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Sunshine-S-SMI	CY 2016	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	10/01/2020–09/30/2021	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
United-C	CY 2016			30.7	42.3		13.5					1.6
	10/01/2020–09/30/2021			18.2	28.66		9.93					4.84

* The performance indicator rates documented in the table are reflective of the rates reported by the plans in the PIP submission. The remeasurment rates are indicated with a green background color when the goal was met and with an orange background color when the goal was not met.

Table D-3—Performance Indicator Rates by Region and Population Served for the Reducing PPEs PIP*

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
PPAs per 1,000 Enrollee Months												
Aetna-C	SFY 2015/2016						1.99	2.16				1.94
	10/01/2020–09/30/2021						2.29	2.26				1.66
AmeriHealth-M	SFY 2015/2016									2.07		1.94
	10/01/2020–09/30/2021									1.19		1.27
Community Care Plan-M	SFY 2015/2016										1.74	
	10/01/2020–09/30/2021										1,11	
Humana-C	SFY 2015/2016	1.64	1.88	2.06	2.08	2.2	1.99	2.16	1.93	2.07	1.74	1.94
	10/01/2020–09/30/2021	1.45	1.63	1.86	1.61	1.95	1.41	1.42	1.17	1.15	1.07	1.17
Molina-C	SFY 2015/2016								1.93			1.94
	10/01/2020–09/30/2021								1.13			1.37
Molina-S	SFY 2015/2016				2.08	2.2		2.16				
	10/01/2020–09/30/2021				1.69	1.61		1.83				
Simply-C	SFY 2015/2016	1.64	1.88			2.2	1.99	2.16		2.07	1.74	1.94
	10/01/2020–09/30/2021	0.96	1.75			1.20	1.04	1.48		1.20	1.05	1.16

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Clear Health-S	SFY 2015/2016	1.64	1.88	2.06	2.08	2.2	1.99	2.16	1.93	2.07	1.74	1.94
	10/01/2020–09/30/2021	0.85	0.55	1.85	0.84	1.31	0.90	1.79	1.24	0.79	0.89	1.17
Sunshine-C	SFY 2015/2016	1.64	1.88	2.06	2.08	2.2	1.99	2.16	1.93	2.07	1.74	1.94
	10/01/2020–09/30/2021	1.83	1.41	1.75	1.48	2.26	1.56	1.70	1.56	1.89	1.72	1.87
Sunshine-S-CW	SFY 2015/2016	1.64	1.88	2.06	2.08	2.2	1.99	2.16	1.93	2.07	1.74	1.94
	10/01/2020–09/30/2021	0.28	1.74	1.65	1.52	0.82	0.36	1.45	0.43	1.10	1.39	0.88
Sunshine-S-SMI	SFY 2015/2016	1.64	1.88	2.06	2.08	2.2	1.99	2.16	1.93	2.07	1.74	1.94
	10/01/2020–09/30/2021	1.42	1.51	1.87	1.45	1.74	1.60	2.06	1.27	1.56	1.41	1.13
United-C	SFY 2015/2016			2.06	2.08		1.99					1.94
	10/01/2020–09/30/2021			1.83	1.8		2.14					1.66
Florida Community Care-L**	10/01/2018–09/30/2019	2.9	0.57	0.42	0.57	0.34	0.71	0.83	0.68	0.25	1.01	0.63
	10/01/2020–09/30/2021	2.94	2.37	2.92	2.76	3.33	2.94	3.63	2.17	2.87	2.49	3.50
PPRs per 1,000 Hospital Admissions												
Aetna-C	SFY 2015/2016						85.87	88.89				98.35
	10/01/2020–09/30/2021						82.74	89.37				80.52
AmeriHealth-M	SFY 2015/2016									94.81		89.54
	10/01/2020–09/30/2021									80.15		73.96

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Community Care Plan-M	SFY 2015/2016										98.95	
	10/01/2020–09/30/2021										89.88	
Humana-C	SFY 2015/2016	89.11	79.18	88.96	88.85	87.73	85.87	88.89	80.95	101.45	98.95	98.35
	10/01/2020–09/30/2021	68.01	55.56	88.11	76.77	78.93	71.99	81.56	74.63	83.86	81.99	81.19
Molina-C	SFY 2015/2016								80.95			98.35
	10/01/2020–09/30/2021								78.65			79.36
Molina-S	SFY 2015/2016				88.85	87.73		88.89				
	10/01/2020–09/30/2021				84.81	81.72		100.18				
Simply-C	SFY 2015/2016	88.85	87.73		88.89	88.85	87.73		88.89	88.85	87.73	
	10/01/2020–09/30/2021	73.33	59.35			79.45	76.98	82.11		82.74	74.44	80.35
Clear Health-S	SFY 2015/2016	89.11	79.18	88.96	88.85	87.73	85.87	88.89	80.95	101.45	98.95	98.35
	10/01/2020–09/30/2021	63.15	136.65	121.73	68.58	121.00	76.13	124.14	80.13	111.45	98.48	97.16
Sunshine-C	SFY 2015/2016	89.11	79.18	88.96	88.85	87.73	85.87	88.89	80.95	101.45	98.95	98.35
	10/01/2020–09/30/2021	76.06	66.76	77.44	70.14	84.47	76.86	85.86	78.58	82.96	85.07	90.76
Sunshine-S-CW	SFY 2015/2016	89.11	79.18	88.96	88.85	87.73	85.87	88.89	80.95	101.45	98.95	98.35
	10/01/2020–09/30/2021	121.59	133.15	138.09	134.52	152.51	169.44	130.34	157.69	147.80	176.09	160.50
Sunshine-S-SMI	SFY 2015/2016	89.11	79.18	88.96	88.85	87.73	85.87	88.89	80.95	101.45	98.95	98.35

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
	10/01/2020–09/30/2021	76.41	78.02	87.14	75.85	88.84	89.29	107.04	88.96	95.83	97.53	95.37
United-C	SFY 2015/2016			88.96	88.85		85.87					98.35
	10/01/2020–09/30/2021			76.74	70.32		70.42					84.87
Florida Community Care-L**	10/01/2018–09/30/2019	0	40.86	0	0	25.64	37.53	46.12	47.46	47.92	73.5	49.71
	10/01/2020–09/30/2021	94.59	68.97	96.74	94.98	105.76	100.56	89.86	109.34	109.02	102.92	153.59
PPVs per 1,000 Enrollee Months												
Aetna-C	SFY 2015/2016						11.57	12.48				8.75
	10/01/2020–09/30/2021						6.65	6.47				5.54
AmeriHealth-M	SFY 2015/2016									23.77		19.51
	10/01/2020–09/30/2021									5.28		5.48
Community Care Plan-M	SFY 2015/2016										8.6	
	10/01/2020–09/30/2021										5.24	
Humana-C	SFY 2015/2016	14.58	12.15	11.16	12.16	10.33	11.57	12.48	10.09	10.49	8.6	8.75
	10/01/2020–09/30/2021	8.97	6.93	6.80	7.04	5.82	6.39	6.39	5.84	5.21	5.63	5.04
Molina-C	SFY 2015/2016								10.09			8.75
	10/01/2020–09/30/2021								6.10			5.66

Plan Name	Measurement Period	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Molina-S	SFY 2015/2016				12.16	10.33		12.48				
	10/01/2020–09/30/2021				11.94	10.80		11.58				
Simply-C	SFY 2015/2016	14.58	12.15			10.33	11.57	12.48		10.49	8.6	8.75
	10/01/2020–09/30/2021	7.63	7.54			6.36	6.33	6.25		4.97	5.98	5.19
Clear Health-S	SFY 2015/2016	14.58	12.15	11.16	12.16	10.33	11.57	12.48	10.09	10.49	8.6	8.75
	10/01/2020–09/30/2021	11.77	12.29	12.05	11.60	9.20	8.40	9.57	7.76	11.98	10.58	9.94
Sunshine-C	SFY 2015/2016	14.58	12.15	11.16	12.16	10.33	11.57	12.48	10.09	10.49	8.6	8.75
	10/01/2020–09/30/2021	8.61	7.73	7.06	7.41	6.23	6.54	6.47	5.58	5.40	5.69	5.23
Sunshine-S-CW	SFY 2015/2016	14.58	12.15	11.16	12.16	10.33	11.57	12.48	10.09	10.49	8.6	8.75
	10/01/2020–09/30/2021	5.53	5.17	5.18	5.65	5.01	5.07	4.79	4.93	4.29	4.92	4.47
Sunshine-S-SMI	SFY 2015/2016	14.58	12.15	11.16	12.16	10.33	11.57	12.48	10.09	10.49	8.6	8.75
	10/01/2020–09/30/2021	14.98	11.27	11.18	11.15	11.27	10.73	11.44	8.94	10.22	11.64	8.66
United-C	SFY 2015/2016			11.16	12.16		11.57					8.75
	10/01/2020–09/30/2021			7.43	7.91		6.70					5.17
Florida Community Care-L**	10/01/2018–09/30/2019	2.41	2.07	1.63	1.01	3.93	2.37	0.75	1.89	1.92	2.77	2.2
	10/01/2020–09/30/2021	4.24	3.42	4.35	4.10	8.02	5.51	3.40	4.93	5.25	4.95	4.21

* The performance indicator rates documented in the table are reflective of the rates reported by the plans in the PIP submission.The remeasurement rates are indicated with a green background color when the goal was met and with an orange background color when the goal was not met.

** Florida Community Care-L reported that the plan received Agency approval to use 10/01/2018–09/30/2019 data as the baseline for this PIP.

Table D-4—Performance Indicator Rates by Region for Reducing Potentially Preventable Dental-Related Emergency Department Visits PIP*

	The remeasurement rates are indicated with a green background color when the goal was met.
	The remeasurement rates are indicated with an orange background color when the goal was not met
The first rate presented for each plan represents the baseline rate.	

Plan Name	Measurement Period	Statewide Rate**
Preventable Dental Emergency Department Visits per 1,000 Enrollee Months		
DentaQuest-D	SFY 2016/2017	0.2584
	10/01/2018–09/30/2019	0.2454
	10/01/2019–09/30/2020	0.171
	10/01/2020–09/30/2021	0.162
Liberty-D	SFY 2016/2017	0.2584
	10/01/2018–09/30/2019	0.2717
	10/01/2019–09/30/2020	0.189
	10/01/2020–09/30/2021	0.177
MCNA-D	SFY 2016/2017	0.2584
	10/01/2018–09/30/2019	0.2294
	10/01/2019–09/30/2020	0.168
	10/01/2020–09/30/2021	0.164

*A lower rate indicates better performance.

**The performance indicator rates documented in the table are reflective of the rates reported by the plans in the PIP submission; these rates are indicated with a green background color when the goal was met and with an orange background color when the goal was not met.

For the Reducing Potentially Preventable Dental-Related Emergency Department Visits PIP, the three dental plans provided statewide remeasurement rates. All three plans met the goal rate for reducing preventable dental ED visits.

Improvement Strategies

A plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP review process, HSAG reviewed the interventions employed by the plans for appropriateness to the barriers identified, and the timeliness of the implementation of the interventions.

Table D-5 displays the interventions as documented by the plans for the Improving Birth Outcomes PIP.[D-1]

Table D-5—Interventions Implemented/Planned for the Improving Birth Outcomes PIP

Plan Name	Interventions Implemented/Planned
Aetna-C	• Identify and educate obstetricians (OBs) and gynecologists (GYNs) with high volume of primary C-sections. • Implement use of a C-section checklist with all network OB/GYNs. • Promote safe and appropriate use of 17P Makena (hydroxyprogesterone acetate) in pregnant women at risk of preterm labor and giving birth prematurely. • Promote prenatal visits via a Prenatal-Postpartum healthy behaviors incentive program. • Redesigned and redefined the Integrated Care Management program for pregnant women. • Neonatal Abstinence Care Management program—Identify and engage pregnant women who have significant opiate use, opioid use disorder, or SUD in high-risk perinatal care management.
AmeriHealth-M	• Healthy Start—AmeriHealth-M has a partnership with Healthy Start to refer all new moms and high-risk pregnant enrollees for assistance with community resources as well as to connect first time moms with a Family Nurse Partnership program that focuses on first time moms at the enrollees' homes. The health plan revised its referral process from an "opt-out" to an "opt-in" approach to increase the number of referrals to Healthy Start. • Keys to your Care Maternity Texting/Two-Way Texting is an enrollee engagement program to encourage enrollees to make and keep doctor's appointments throughout their pregnancy and postpartum period. Offer rewards to enrollees who have completed 10 out of 13 prenatal visits and a postpartum visit within seven to 84 days of delivery. • Offer doula services to pregnant mothers. • In addition to educating enrollees on the importance of long-acting reversible contraceptives (LARCs), the health plan will also identify providers that work in LARC-approved facilities in regions 9 and 11 and educate providers on the availability of LARC unbundled payment. • AmeriHealth-M in collaboration with pharmacy vendor PerformRx will promote the use of progesterone treatment to help prevent premature births. This initiative also includes an at home program for administration of the Makena for enrollees who are high risk and meet criteria inclusive of noncompliance with attendance at OB appointments. • Train OB providers on SBIRT regarding SUD.

[D-1] Children's Medical Services-S and Florida Community Care-L did not participate in the *Improving Birth Outcomes* PIP.

Plan Name	Interventions Implemented/Planned
Community Care Plan-M	• The OB Care Management team receives a daily bed census report that is compiled from Broward Health, Memorial Healthcare System, and the Encounter Notification Service (ENS). The report includes the emergency room (ER) and inpatient utilizers and is analyzed daily to identify enrollees that indicate a potential pregnancy (e.g., threatened abortion) for outreach and enrollment into OB care coordination. • Obstetrical risk assessments are completed via phone utilizing a Health Risk Stratification Assessment Tool to identify the risk of a pregnant enrollee. • OB/GYNs who are in-network for six consecutive months, sign a pay for performance (P4P) program agreement, and achieve the 75th percentile for given access and quality measures and the 60th percentile for the other measures during the measurement period will be paid at a Medicare rate. • A pregnant enrollee receives a $50 reward for obtaining a prenatal exam with an OB during her first trimester and a postpartum exam with the OB between three and seven weeks of the delivery date.
Humana-C	• Enrollment into the Moms First Case Management program and other programs to address psychosocial determinants of health. • Best Foot Forward Campaign—Call center outreach to enrollees that the other health plan staff have been unable to reach. • SBIRT—Information/strategies for encouraging OB providers to implement SBIRT for all pregnant enrollees. Verify, engage, and refer enrollees to medication-assisted treatment therapy. • Maternity Home Visiting/Remote Monitoring program, which provides skilled nursing care to reduce costs and improve clinical outcomes for the mother and infant. • Doula Services—Expand the network of doula providers, benefits changes, and increased reimbursement rate. • Revised Health Risk Assessment and Notification of Pregnancy form for identification of risk.
Molina-C	• OB/GYN Provider Profiling targets cost implications for providers with high C-section rates. Decreasing reimbursement rates for C-sections and increasing reimbursement rates for vaginal deliveries. • Enhanced methods to identify pregnant enrollees utilizing multiple sources such as: claims data, pregnancy notification forms from providers, and panel roster. Telephonic educational outreach conducted to newly identified pregnant enrollees to improve birth outcomes. • Member Location Unit (MLU) attempts to contact the enrollee as early as possible to coordinate prenatal care, complete prenatal risk assessments, and coordinate referral to any identified needs to improve birth outcomes. • Enhanced prior authorization review of inpatient admissions for deliveries to include review for elective early deliveries and planned C-sections to ensure medical necessity and appropriateness. This includes application of a policy to not approve or pay for elective early deliveries or non-medically appropriate primary C-sections. • Provider outreach and education regarding early identification of substance use in pregnant enrollees and appropriate BH referral.

Plan Name	Interventions Implemented/Planned
	• Healthy Behaviors programs to include interventions and incentives to enrollees for meeting treatment milestones related to participation in prenatal substance use programs. • Identify enrollee needs for 17P progesterone therapy during pregnancy. • Continue including LARC education and coordination as part of the High-Risk OB program.
Molina-S (Molina-C reported separate interventions for their specialty population for this PIP)	• Continue to monitor the OB/perinatal specialists that treat enrollees with serious mental illness (SMI) and SUD. Encourage coordination between OB and BH providers. • Through provider engagements, provider groups are made aware of pregnant enrollees to follow up with their treatment. • Case management support and care coordination for existing comorbidities. • The High-Risk Maternity team tracks and trends pregnant enrollees with a history of SUD to increase number and frequency of screenings and counseling. • Offer the 17P program to those enrollees in need of progesterone therapy to lower preterm birth rates.
Simply-C (includes Clear Health-S)	• Identify and engage pregnant women in their first 20 to 24 weeks of gestation and who currently have substance abuse issues. • Gestational Diabetes Pilot—Home-delivered meals to high-risk enrollees with a history of preterm labor, preterm deliveries, and high blood pressure. • OB Quality Incentive Program offers incentives to OB providers to provide quality and efficient care, while keeping enrollees' healthcare needs primary.
Sunshine-C (includes Sunshine-S-CW and Sunshine-S-SMI)	• Enroll pregnant mothers in Start Smart for Your Baby program. • Collaborate with Healthy Start Coalition and other community stakeholders to identify and engage pregnant mothers. • Value-Based Purchasing (VBP) Program—(P4P for obstetric providers. • Provider education on opioid use and Trauma Informed Care approach. • Use of telemedicine appointments with BH providers for pregnant enrollees with SUD.
United-C	• MMA Physician Incentive Program. Qualifying providers are required to have multiple accreditations and/or meet HEDIS performance for prenatal/postpartum care and C-section rate goals. • Caesarean deliveries that are performed electively and do not include a high-risk diagnosis will be reimbursed at a lower amount. • Encourage OB providers to engage with the Florida Perinatal Quality Collaborative. • Partnership with March of Dimes on implementation of innovative supportive pregnancy care programs. Small pilot to take place in Region 11 with an OB provider practice. March of Dimes to lead prenatal visits in groups for women at the participating practice. Groups consist of educational sessions and peer's support. • Provider incentive programs that reward providers for helping enrollees to become more engaged in their preventive health. • Healthy First Steps partnership with Healthy Start Coalition to support engagement of difficult to engage pregnant enrollees.

Plan Name	Interventions Implemented/Planned
	• 17P/Makena Home Delivery program by OB RNs. This program includes full maternal/fetal assessments at each visit. • Healthy First Steps High Risk Case Management and Rewards program. • Pharmacy Management Solutions to identify pregnant women timely. • National Doula Network—Refer high-risk pregnant members to doula services. Doula services provide emotional, physical, and informational support during the prenatal and postpartum period, as well as during delivery. • Brave Health—Provides telehealth enabled therapy and psychiatry, medication management, and support to high-risk enrollees. • SBIRT Enhanced Provider Toolkit—UnitedHealthcare, in collaboration with Optum Behavioral, developed a communication that contains multiple links to education about SBIRT and treatment of SUD for the maternity population. • Maternity Episodes of Care—Episode/Bundle Payment program that pays for value and increases risk sharing. Rewards OB providers for achieving quality measures, increasing care coordination, and reducing cost. • Wellhop for Mom and Baby Pilot—Pregnant enrollees with similar due dates meet virtually for group learning and connection.

Table D-6 displays the interventions as documented by the plans for the Reducing PPEs PIP.[D-2]

Table D-6—Interventions Implemented/Planned for the Reducing PPEs PIP

Plan Name	Interventions Implemented/Planned
Aetna-C	• Initiate measures to increase access for all enrollees to primary care and BH services including telehealth and home physician visits. • Enroll enrollees with complex medical conditions (chronic obstructive pulmonary disease [COPD], diabetes, SMI, heart disease, congestive heart failure [CHF]) into intensive care management and include pharmacy, RNs, and community health workers in care management team. • Promote use of 24-hour nurse information line and 24-hour BH hotline, which are available for all enrollees. • Increase the number of primary care providers (PCPs) and specialists in value-based arrangements which reward providers for extended and weekend hours and indirectly tie provider compensation to appropriate ED usage.

[D-2] Children Medical Services-S did not participate in *Reducing PPEs* PIP.

Plan Name	Interventions Implemented/Planned
AmeriHealth-M	• For reducing PPAs, PPRs, and PPVs: – Value-based contracts provide additional revenue for practices that deliver high-quality and cost-effective care. – Telemonitoring and mobile health coaching via the Vheda Health tool. This service is offered to enrollees diagnosed with poorly controlled diabetes mellitus or CHF. – Two-way texting campaign connects case managers with high-risk enrollees, allowing to initiate a conversation via a text message from their mobile device. • For reducing PPAs: – Predictive modeling proactive outreach approach. – Care management outreach by an RN case manager. – Medication adherence program: As part of the case management program for enrollees identified as high risk: the case manager will review the enrollee's medications via telephonic outreach. – The case managers conduct the social determinants of health screening during the initial assessment, which is completed via telephonic case management process. • For reducing PPRs: – Enhanced TOC, care coordination, community case management programs. • For reducing PPVs: – The ER Diversion Outreach program enlists a multi-faceted approach with focus on intake, education, prevention, and interventional opportunities. The targeted population includes the top 400 ER utilizers and the top 400 ER cost enrollees identified through data mining and HIE data. In addition to HIE data, an ER diversion texting campaign implemented for children and adults to improve the efficiency of outreach attempts to enrollees with high ER utilization. – Telemedicine: Partnered with MDLIVE to help increase enrollees' use of telehealth services.
Community Care Plan-M	• Telemedicine—The health plan is working to design a policy and program that will enable access to telemedicine in care settings that meet the state requirements, for enrollees in need of care in which access to care is challenging due to limited providers, appointment availability, or where enrollee transportation issues exist. • LACE Initiative—The health plan utilizes the LACE tool to identify enrollees that are at high risk for readmission. LACE is defined as length of stay, acuity of the admission, comorbidities using the Charlson comorbidity index, and ER visits in the past six months. This tool is utilized on all enrollees who are admitted and placed on the ER/Inpatient Bed Census for daily review and intervention by the Concierge Care Coordination team. • Daily Bed/Census review utilizes daily reports to identify members to contact and obtain their discharge needs.

Plan Name	Interventions Implemented/Planned
Florida Community Care-L	• Network oversight and management related to routine and preventive care will consist of coordination with care managers and provider relations (PR) staff to communicate directly to providers that have not identified or coordinated care that results in poor or inadequate outcomes. Target lists of enrollees and their affiliated providers will be reviewed by care management leadership and PR leadership to develop intervention focus on both enrollee and provider education and improvement in outcomes. • FCC-L engaged with a medication therapy management (MTM) vendor to conduct comprehensive medication reviews for the enrollees. • FCC-L hired two HEDIS nurses to improve HEDIS scores through provider education and enrollee engagement.
Humana-C	• For reducing PPAs—Enhance case management outreach and engagement to focus on enrollees with the top driver admission diagnoses CHF and COPD. • For reducing PPRs: − Enhance discharge planning, care transitions, and post discharge care coordination to focus on high-risk enrollees and top driver readmission diagnosis. Provide targeted post-discharge outreach calls and assessments to enrollees. − Provide outreach to enrollees during hospitalization (within one business day from determination) to conduct discharge planning. • For reducing PPVs: − Improve enrollee engagement by conducting outreach during ED visits. − Enhance enrollee post-ED visit education. − Smart Alerts ED Outreach Pediatric Pilot. − Improve enrollee access to urgent care, telemedicine, Dispatch Health, and PCPs in targeted regions; enhance PCP education.
Molina-C	• Disease management and care coordination interventions using iPro predictive modeler for enrollee identification based on clinical risk and impact level along with other identifiers. • An assigned case manager to provide education, care coordination, self-management teaching for enrollees identified with a chronic condition and two or more admissions for high volume PPA admission condition within a three-month period. • Disease management and care coordination interventions for the prevention of inpatient admissions for the top 10 conditions for PPA and PPR. The program will utilize a LACE score and other predictive modeling tools to indicate risk for hospital admission and identify target population. • Identify enrollees with one or more ER visit(s) for any period of time for any of the top 10 PPV conditions and evaluate the root cause of utilizing the ER versus PCP or urgent care. • Overall enrollee outreach and education to reinforce availability of alternatives to the ER including telehealth, urgent care centers, and Nurse Advice Line.

<table>
<tr><th>Plan Name</th><th>Interventions Implemented/Planned</th></tr>
<tr><td>Molina-S</td><td>
For reducing PPAs:

Transition model to enhanced iPro condition-specific data to be utilized monthly to identify leading PPA conditions for intervention.
Care Management teams outreach providers to educate about assigned enrollees with open gaps in care.
Direct outreach and follow-up with enrollees in the community, in their homes, at hospital admission/discharge to close gaps in care, educate on use of PCP/health home services, alternatives to ED, and use of nurse advising services.

For reducing PPRs:

LACE scoring updated weekly at the time of admission, identified high-risk enrollees can be triaged to determine the appropriate discharge transition tactics.
Care and Discharge Transitions Programs provide outreach and follow-up care after hospitalization.

For reducing PPVs:

ED Diversion Program utilizing analytics to identify enrollees with high ED utilization. High Utilizers receive face-to-face or telephonic follow-up by the Care Management team.
Determine ability to expand network contracting for urgent care services, same-day access, providers with extended hours, and mobile crisis services.
Utilize ENS data to support timely follow up for members following both hospital and ED visits.

</td></tr>
<tr><td>Simply-C</td><td>
Enhanced the TOC program—The program's objective is to bridge the gap between the health plan and hospitals through the following process:

Pre-Cert notifies inpatient coordinators (ICs) of planned admissions.
IC provides pre-admission planning to enrollees and works with concurrent review nurse and hospital to determine enrollee transition needs. IC coordinates transition to a skilled nursing facility, rehab, nursing home, and does discharge notification.
Discharge caller contacts enrollees within 24 to 72 hours post-discharge to coordinate discharge follow-up plans.
TOC coordinator reviews discharge and triages for care management assignment daily.
TOC nurse visits enrollee within seven days and follows enrollee for 30 days post-discharge.

Telemonitoring programs aimed at enrollees with COPD, CHF, and diabetes. The plan contracts with First Quality Home Care, an organization that provides home healthcare services, to provide its enrollees with remote patient monitoring equipment.
Identify and engage asthma enrollees who are noncompliant with their medications and have no ED visits and/or hospital admissions in the fiscal year.
Improving ENS notification utilization by customized PPE alerts.
</td></tr>
</table>

Plan Name	Interventions Implemented/Planned
Sunshine-C (includes Sunshine-S-CW and Sunshine-S-SMI)	• For reducing PPAs: – Apply population management approach to identify enrollees for case management. – Increase use of telemedicine to improve access to specialty care for enrollees with chronic conditions in rural areas. • For reducing PPRs: – Apply clinical programs on readmissions—Use daily inpatient census report to identify enrollees who may benefit from case management. – Apply clinical programs on readmissions including top readmit diagnoses of mental health. • For reducing PPVs: – Apply current ER diversion and other clinical programs to ED utilization. – Implement 24/7 telemedicine program to increase access to urgent physician services outside of the ER.
United-C	• Certified Peer Support Specialists—This program assigns a peer support specialist to enrollees with a mental health/substance abuse condition to help enrollees comply with their outpatient visits, medication, and navigate the system overall. • Event Notification System and Community Care—These two electronic systems will allow prompt identification of enrollees with inpatient admission. • Remote Patient Monitoring—Implement high-tech/high-touch home monitoring for enrollees with chronic conditions/or at risk of COPD, CHF, and diabetes. • Team MD—Pilot program in Region 4 to provide integrated primary care model, where the PCPs lead collaborative care teams. • Clinical Disease Management program—Enrollee education on proper ER utilization and home self-management practices. • Payment Methodology Changes—Use of low acuity diagnoses to drive payment methodology changes with particular focus on ER trends. • MTM program that targets enrollees with asthma/COPD, diabetes, and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and who are not taking their medications. • PPE data sharing with underperforming providers to increase provider and member education. • 24/7 telephonic support is offered as an after-hours clinical support program. • High-Risk Patient Management (ACO program)—This initiative will focus on high-risk patients who have not had an office visit in 90 days to schedule an in-office appointment. • Weekend End Tuck in Program (ACO program)—This initiative will focus on reducing ED visits for non-emergent issues during the weekends.

Table D-7 displays the interventions as documented by the dental plans for the Potentially Preventable Dental-Related Emergency Department Visits PIP.

Table D-7—Interventions Implemented/Planned for the Potentially Preventable Dental-Related Emergency Department Visits PIP

Dental Plan Name	Interventions Implemented/Planned
DentaQuest-D	• Broken Appointments—Providers can submit a dental claim any time an enrollee missed or cancelled a dental appointment. DentaQuest-D contacts the enrollee by automated phone call or postcard mailer reminding them of the importance of dental care and encourages them to call their dental home provider to reschedule the missed appointment. • Implementation of ED Redirect Program—DentaQuest-D identifies enrollees who have used the ED for any dental-related issues and outreaches to these enrollees to assist in finding a dentist or changing dental home. • Case management for enrollees who continue to have ED visits. DentaQuest-D case managers outreach to enrollees to help educate enrollees about their dental plan benefits and help schedule a dental appointment.
Liberty-D	• Development and implementation of data sharing and joint care coordination agreements between prepaid dental and health plans to capture data associated with dental-related PPVs and include real-time notification. • CSR will connect enrollees having dental pain/discomfort with their dental home. If the CSR is unsuccessful, they will locate another facility to provide ER services. After-hours calls are handled by Liberty-D's 24/7 on-call staff dentists who can triage the enrollee's concern and assist the enrollee. • Use of VBP provider incentives. • Early Smiles program, in areas with the highest rates of PPVs, that allows Liberty-D to provide preventive dental services and help navigate children to a dental home through school-based partnerships and use of mobile dentistry outreach, education, and treatment in collaboration with County School Districts and the Florida Department of Education. • Text message campaign to promote healthy behaviors, highlighting the importance of dental wellness and overcoming access to care barriers by giving another avenue for information.
MCNA-D	• Hygienist Helpline enables members to discuss their dental concerns with a professional and helps find the best provider for their needs. • Care gap alerts to MSRs offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac™ system during inbound calls that indicates the enrollee is overdue for a preventive dental visit. • Enrollee Pre-authorization Outbound Calls—MCNA-D's Care Connections Team conducts outbound calls to enrollees who have unused pre-authorization requests on file. • Provider Pre-authorization Outbound Calls—MCNA-D's PR team conducts outbound calls to provider offices with a high volume of unused pre-authorization requests and provides them with a list of enrollees.

Dental Plan Name	Interventions Implemented/Planned
	• Provider Portal Preventive Service Gaps—Real-time Early and Periodic Screening, Diagnostic, and Treatment preventive dental service gaps visible to providers at the time of eligibility verification in MCNA-D's Provider Portal. • Targeted PR Outreach for Treatment Services—Targeted visits to dentists who, based on dental record review, have not completed documented treatment needs.

Appendix E. Plan-Specific Progress in Meeting EQRO Recommendations

Introduction

Regulations at §438.364 require an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR. This appendix provides a summary of the follow-up actions per activity that the plans reported completing in response to HSAG's SFY 2021–2022 recommendations. Please note, content included in this section is presented verbatim as received from the plans and has not been edited or validated by HSAG except for formatting bullets for consistent presentation.

Scoring

HSAG worked with the Agency to develop a methodology and rating system for the degree to which each plan addressed the prior year's EQR recommendations. In accordance with CMS guidance, HSAG used a three-point rating system. The plan's response to each EQRO recommendation was rated as *High*, *Medium,* or *Low* according to the criteria below.

High indicates *all* of the following:

- The plan implemented new initiatives or revised current initiatives that were applicable to the recommendation.
- Performance improvement directly attributable to the initiative was noted *or* if performance did not improve, the plan identified barriers that were specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming identified barriers.

A rating of *high* is indicated by the following graphic:

Medium indicates one or more of the following:

- The plan continued previous initiatives that were applicable to the recommendation.
- Performance improvement was noted that may or may not be directly attributable to the initiative.
- If performance did not improve, the plan identified barriers that may or may not be specific to the initiative.
- The plan included a viable strategy for continued improvement or overcoming barriers.

A rating of *medium* is indicated by the following graphic:

Low indicates one or more the following:

- The plan did not implement an initiative or the initiative was not applicable to the recommendation.
- No performance improvement was noted *and* the plan did not identify barriers that were specific to the initiative.
- The plan's strategy for continued improvement or overcoming identified barriers was not specific or viable.

A rating of *low* is indicated by the following graphic:

Plan Follow Up

Comprehensive Plans

Aetna-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • ABH-FL did not conduct a formal root cause analysis our focus study to determine why members do not consistently access preventive and ambulatory services however this root cause analysis will be conducted no later than Q2 2024
b. Describe initiatives implemented based on recommendations: • ABH-FL implemented the following initiatives as a result of other priorities but related to telehealth access and access to preventative care including: provider monthly trainings contain telehealth information, standing provider survey to update provider's telehealth access, provider directory attribute to identify if provider offers telehealth, contracts with several specialty telehealth providers (e.g., behavioral health), continued single case agreements for any members to access care for provider not yet in network, addressing member assist requests to ensure members can access care quickly, education to providers on access to care requirements, quarterly review of non-par claims to identify providers for recruitment.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None at this time. No formal measurement has been implemented.
d. Identify any barriers to implementing initiatives:

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• None at this time.
e. Identify strategy for continued improvement or overcoming identified barriers: • None at this time.
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why women are not receiving breast cancer screenings. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving breast cancer screenings.
Response
• Describe why this weakness exists: • There have been deficits in breast cancer screening amongst Medicaid members in the past, but since the PHE there have been additional challenges found, including members having increasing difficulty getting an appointment, likely due to the rebound of cancer screenings. We will conduct a root cause analysis after the 2023 measurement year to determine if there are any specific reasons why our members are not receiving screening, which will also include considering the measure differently due to the migration to an e-measure and determining if clinical data flow could be impacting the rate (there are concerns that members who have had bilateral mastectomies and are exclusions for the measure will not be adequately accounted for in the e-measure).
• Describe initiatives implemented based on recommendations: • Although we don't have interventions based on a new analysis, we have created mailers and are working on a script for outreach. We will be applying our health equity dashboards onto members in the measure to determine reach of facilities, and through our outreach we will identify additional barriers for which we will develop interventions.
• Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
• Identify any barriers to implementing initiatives: • There is concern about availability of appointments for members given the difficulty making appointments currently. Member contact information is a barrier to successful outreach.
• Identify strategy for continued improvement or overcoming identified barriers: • We will be working with key facilities to try to find solutions to the local bottlenecks (this is agnostic of Medicaid and is currently an issue throughout Florida).
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members with diabetes are not receiving eye exams (retinal). Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving eye exams (retinal).
Response
a. Describe why this weakness exists: • There is not one clear reason why members are not receiving diabetic retinal eye exams. However, barriers such as transportation and member belief of lack of necessity have been identified as two member reported reasons. Members also reported concern with eye dilation. A deeper analysis will be conducted after the end of the HEDIS year to determine any additional possible drivers of low compliance.
b. Describe initiatives implemented based on recommendations: • Aetna Better Health of Florida has implemented additional assistance with transportation, home eye exams, and member outreach by both the health plan and the eye vendor to close member eye exam gaps. Gaps in care lists have been provided to key primary care providers so they can have conversations with their patients and help guide them to care.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • So far in this measurement year there hasn't been significant improvement in eye exam rates. It is unclear why with such extensive outreach rates have not been increased, but at least a full year of HEDIS data is critical for a full end to end analysis.
d. Identify any barriers to implementing initiatives: • Member contact information has been an issue for successful live outreach. The reliability of the transportation vendor was an issue in certain circumstances.
e. Identify strategy for continued improvement or overcoming identified barriers: • Aetna Better Health of Florida is looking for additional solutions to moderate transportation options for members. Educating members on availability of home eye exams will be expanded. A provider incentive program is in final development. Member contact information improvement program will be considered. Additional analysis will be completed, including leveraging SDOH information on non-adherent members is slated for after the measurement year ends.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* measure (both indicators).

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Response
a. Describe why this weakness exists: • Individuals are not ready, willing, or able to engage in active change on addressing the substance use disorder, members are hard to reach or unable to be reached, they are functioning at a level where they do not feel that their substance use has impacted them negatively, members/parent or guardian in denial that the substance use is pathological, refusal for assistance. Providers who do not have an integrated practice are screening and diagnosing but may not have a closed loop referral to ensure that the individual has followed up with referral for treatment. There continues to be stigma related to substance use and those with co-occurring disorders and SDOH needs typically are more willing to engage in services that make an impact on their basic needs or those which do not hold stigma.
b. Describe initiatives implemented based on recommendations: • The following interventions have been implemented to make an impact holistically on behavioral health and substance use disorder measures: adding additional telehealth providers so that members can receive care in an environment of their choice. We have contracted with a value-based medication assisted treatment provider. We recently insourced our behavioral health benefits and included peer support specialists as part of the behavioral health team. We have implemented clinical staff members doing initial outreach for specific members who been identified with a substance use disorder. We have promoted the use of SBIRT screening with our provider network and have conducted and will expand upon SBIRT trainings for our provider network. We are holding daily behavioral/substance use disorder rounds that is comprised of a multidisciplinary team, have constructed workgroups which focus on the SDOH needs of members who have behavioral health and substance use. In addition, we continuously use the ENS system to garner additional or most current contact information. Currently in process of pursuing strategic network development and partnerships to assist in engagement of members.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We are continuing to monitor and will be developing more specific/targeted interventions and performance improvements with future interventions that will be underway.
d. Identify any barriers to implementing initiatives: • There are significant confidentiality requirements surrounding substance use and the sharing of such information. Additionally, many members are in differing stages of change as it pertains to accessing services for substance use whether it be denial, pre-contemplation, or contemplation. It often takes a considerable amount of time to work with individuals prior to them accepting help and thus do not meet the timeframe for making an impact on the HEDIS® measure.
e. Identify strategy for continued improvement or overcoming identified barriers: • The health plan will be doing a further study on the measure, members, and where they are being seen, who can assist us in internally and externally to make an impact and developing more specific and targeted interventions.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • Members are commonly discharged from in-patient (IP) facilities without a follow-up appointment, and once they are discharged it is difficult to find them or engage them to get them an appointment. When you do find the member, if they don't decline care, it is often too late to make a timely appointment. Another issue is finding providers who can accommodate 7 day appointments. Members additionally have barriers to care such as transportation, and for telehealth appointments, the lack of technology or technical skills is a problem. IP data has also been a barrier to timely appointments as the health plan is not always notified of admissions or discharges timely.
b. Describe initiatives implemented based on recommendations: • Daily member outreach to confirm 7 day follow up appt. • Coordinate behavioral health (BH) appts based on members preferred date and time. • Provide telehealth appts when no in office appt is available within 7 days. • In-services for in-patient (IP) facilities. • Collaborate with PCP practices who offer medical and BH to see their members within 7 days. • Identifying high utilizers and members with SDoH to coordinate care internally across departments (CM, UM, etc.) via biweekly Collaborative Care Team meetings (CCT)
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • 33% higher compliance rate with member outreach. • 75% higher compliance rate in quarter 2-2023 with telehealth solo practitioner. • 3.33% successful outcome rate from CCT collaboration within 3 months.
d. Identify any barriers to implementing initiatives: • IP facilities unwilling to discuss provider education. • IP facilities frequently referring to outpatient (OP) practices who are unable to see members within 7-day timeframe. • Limited availability for bilingual providers. • Inability to outreach members due to incorrect or outdated phone numbers.
e. Identify strategy for continued improvement or overcoming identified barriers: • Consider incentivizing 7-day follow up appt for most frequented OP practices. • Work with Chief Medical Officer (CMO) to collaborate with IP facilities to engage in provider education. • Look for opportunities to improve member contact information.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for LTC Program
HSAG recommended the following: • Regarding the *LTSS Minimizing Institutional Length of Stay* measure, evaluate care coordination processes to determine whether there are opportunities to enhance the methods in which the plan engages with members and facilities to support successful discharges to the community. For example, the plan should determine if it is effectively using all available data and information collected during a member's initial facility admission, as well as upon hospital discharges to the facility, so that effective discharge planning occurs. Additionally, the plan should assess whether it has adequate community support in place to facilitate members successfully transitioning to reside in a community setting within 100 days of admission to a facility.
Response
a. Describe why this weakness exists: • The response to the PHE had a significant impact on the transition of members from facilities back to the community. Families and ALFs (Assisted Living Facilities) were either unwilling or unable to accept members. Case Managers (CMs) were not permitted to conduct in-person visits. Facilities were not equipped to handle the high volume of calls to conduct telephonic reviews. Rebalancing needed to occur naturally via the family. Members testing positive to PHE were not able to be discharged and could not be transferred home while someone in the home tested positive, resulting in longer than average stays in the facilities.
b. Describe initiatives implemented based on recommendations: • Many of the issues resulting from the restrictions placed during the height of the pandemic have gradually improved. Utilizing technology i.e.: Video calls to conduct assessments, allowed CMs the ability to assess members and interact with families to arrange transitions back to community.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable
d. Identify any barriers to implementing initiatives: • Not all families have access or insight to utilize video calls. Also, facilities are not adequately staffed and/or have access to the technology to conduct video calls.
e. Identify strategy for continued improvement or overcoming identified barriers: • Currently, CMs are able to conduct in person visits in both the community and facilities which allow for more effective planning of transition back into the community.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Interventions
HSAG recommended the following: • Aetna-C had an opportunity for improvement in the evaluation of the effectiveness of interventions for the Administration of Transportation Benefit PIP. For unsuccessful interventions, the plans should make data-driven decisions to revise the current intervention or discontinue it and implement new interventions. • The plans should consider using QI science tools such as process mapping, FMEA, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small scale using PDSA cycles should be ramped up and adopted planwide in order to impact the entire eligible population.
Response
a. Describe why this weakness exists: • For the baseline (BL) there were no interventions to test as it was only a baseline year. However, once the interventions were implemented, data analysis was completed.
b. Describe initiatives implemented based on recommendations: • ABHFL implemented the key driver diagram to test the current intervention.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Leg A reported for the PIP submitted for CY 2022 (R2) was 91.4% which exceeded the goal of 90%.
d. Identify any barriers to implementing initiatives: • Not applicable.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to monitor interventions in place, utilizing data-driven science tools, specifically the key driver diagram to identify and prioritize barriers and opportunities for improvement.
HSAG Assessment

Humana-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • In our effort towards continued improvement of members' access to preventative and ambulatory services, Humana Healthy Horizons in Florida ™ (FL HHH) Population Health Management (PHM) data monitoring strategies continuously inform new opportunities for analysis and intervention. Our program is designed to provide services and supporting information to our entire population, recognizing the member level of need, and tailoring our interventions systematically. Following a root cause analysis to determine why members did not consistently access preventative and ambulatory services, FL HHH determined the following: − High volume of difficult to reach members with limited and/or invalid contact information (Unable To Contact (UTC) members). − Low member engagement and awareness of the importance of an annual visit and appropriate places to seek care. − Lack of provider awareness of members requiring an annual wellness visit. − Limited access or availability to primary care physician (PCP) care for some members due to shortage of staff.
b. Describe initiatives implemented based on recommendations: • To address barriers identified for why members did not consistently access preventative and ambulatory services, FL HHH developed the following interventions: − Multi-modal process to target and outreach non-compliant members who are UTC to attempt to engage the members including initiating face to face outreach, social media and texting campaigns. Communication includes information on member resources and programs for education, engagement, availability of transportation benefits, and member reward opportunities. − Programs to educate, engage, and incentivize members for attending their annual wellness visit and educated on the importance of seeking non-emergent care at their assigned Primary Care Physician's (PCP) office instead of the Emergency Department (ED). − FL HHH developed provider tools to promote awareness and shared member reporting to inform providers of opportunities to engage members who require an annual wellness visit and addressed provider specific needs and barriers. − FL HHH offered telehealth and remote care options and educated members on available options.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The *Ambulatory Care (per 1000 Member Months)-ED Visits-Total* measure rate for MY2021 exceeded the National Committee for Quality Assurance (NCQA) 50th percentile benchmark. For MY2022, the "Member Months" definition in calculations changed to member years. The MY2021 rate is not comparable to the MY2022 rate. • Data evaluation is ongoing to determine performance improvement for 2023.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
d. Identify any barriers to implementing initiatives: • Barriers to implementation of member outreach/education include: − Low UTC member engagement in requested activities and lack of updating of member contact information despite outreach modalities. − Low member interaction with available member incentive program. − Internet availability in some regions of the state.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Identify best practices for ensuring children and adolescents receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children and adolescents not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.
Response
a. Describe why this weakness exists: • Nearly 50% of the Florida MMA membership includes child and adolescent members. In our effort towards continued improvement of vaccination rates, FL HHH PHM data monitoring strategies continuously inform new opportunities for analysis and intervention. Our program is designed to provide services and supporting information to our entire population, recognizing the member level of need, and tailoring our interventions systematically. Member education is continuous within all health tiers and includes direct to member messaging via social media, written communications, targeted community-based programs, and care management. Following a root cause analysis to determine barriers to children and adolescents receiving medically appropriate preventative vaccines, FL HHH determined the following: − A high volume of members with limited and/or invalid contact information (UTC members). − Lack of member awareness and knowledge of the importance of scheduled immunizations which contributed to member refusal or vaccine hesitancy. − Lack of provider awareness of members with immunization opportunities. − FL HHH also identified the removal of school-based immunizations, especially the flu vaccine from major school districts here in FL as another contributing factor that tends to lower overall immunization rates among children and adolescents.
b. Describe initiatives implemented based on recommendations: • To continuously improve upon barriers to contact and engage difficult to reach members FL HHH has implemented various methods for outreach using internal and external resources to locate and engage members, as well as omni-channel communication campaigns including social media. Communication includes information on member resources and programs for education, engagement, and incentives. • Continued follow-up to outreach and engage members to request participation in activities and updating of their contact information.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Provider engagement and support activities include education of available self-service tools for reporting and monitoring, as well as offering of resources to assist providers in managing members. Individualized support to address provider specific needs and barriers is also offered. • FL HHH developed reporting for providers to help identify members with immunization opportunities.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The *Immunizations for Adolescents-Combination 1* measure rate increased to 71.29% for MY2022 from the MY2021 rate of 70.78% but remains below the NCQA 50th percentile benchmark. • Data evaluation is ongoing to determine performance improvement for 2023.
d. Identify any barriers to implementing initiatives: • Inability to promote member awareness and knowledge of the importance of scheduled immunizations for UTC members. • Low member engagement in requested activities and lack of updating of member contact information.
e. Identify strategy for continued improvement or overcoming identified barriers: • To improve upon barriers to contact and engage difficult to reach members, FL HHH has continued to explore methods and strategies for outreach using internal and external resources to locate and engage members, as well as omni-channel communication campaigns including social media. • Providers and members are educated and provided details on the availability of telehealth and remote care options. • Continue quarterly data trending and drill-down to identify any disparities within populations that contribute to lower performance in a particular race, ethnicity, age group, or geographic area and mitigate barriers, evaluate successful intervention progress, and measure effectiveness on improvement in these areas. • Collaborate with community-based organizations and other local health organizations that promote immunizations to increase community awareness of the importance of staying up to date on immunizations.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • Following a root cause analysis of behavioral health (BH) post-discharge follow-up care in collaboration with Behavioral Health partners, FL HHH determined opportunities in the following: − Inpatient facilities' pre-discharge planning efforts, communication with outpatient providers, and scheduling of outpatient (OP) appointments. − Lack of access and availability of behavioral health appointments creates difficulty in timely follow-up care.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • FL HHH developed interventions to enhance discharge planning, care transitions, and post-discharge care coordination, including member outreach and provider collaboration strategies. − Continued focus on engaging members immediately post-discharge could improve compliance with both the 7 and 30-day Follow-Up appointments. • FL HHH developed interventions to promote telehealth utilization and expansion to address lack of access and availability of appointments.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The *Follow-Up After Hospitalization for Mental Illness (FUH) 7-day Follow-Up* measure achieved statistically significant performance improvement for measurement year (MY) 2022 when compared to the MY2019 baseline. However, the 30-day Follow-Up measure continues to be a focus for improvement strategies. • Data evaluation is ongoing to determine performance improvement for 2023.
d. Identify any barriers to implementing initiatives: • Member outreach barriers included a high population of unable to reach members, and members with invalid phone contact numbers. • Members were declining BH services or seeking care through a Primary Care Physician (PCP). • Gaps with discharging facilities following required processes to ensure timely member appointment scheduling and notification of inpatient admissions and discharges to outpatient providers. • Appointments being scheduled with Community Mental Health Centers instead of the member's previously established provider, leading to delays with rescheduling. • Lack of access and availability of follow-up appointments due to staffing shortages resulting from the PHE pandemic. Some members are not linked to a BH provider impacting Access to Care.
e. Identify strategy for continued improvement or overcoming identified barriers: • Increase member outreach efforts to improve the effectiveness of discharge planning, TOCs, and post-discharge care coordination by educating and engaging family/caregivers and utilizing resources to access accurate member contact information. • Continue provider collaborative efforts to improve the effectiveness of discharge planning, TOCs, and post-discharge care coordination by utilizing resources and conducting data drill-down to identify additional educational and support opportunities to ensure timely appointment scheduling and notification of inpatient admissions and discharges. • Continue to educate and promote scheduling of telehealth appointments to improve timely access and availability to follow-up care. • Continue quarterly data trending to identify and mitigate barriers, evaluate successful intervention progress, and measure effectiveness on improvement in these areas.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why members who access the ED for mental illness or for AOD are not accessing or receiving timely follow-up care and establish potential performance

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.
Response
a. Describe why this weakness exists: • In our effort towards continued improvement of members accessing timely follow-up care after ED visits for mental illness or AOD abuse or dependence, data monitoring strategies in collaboration with our BH partners continuously inform new opportunities for analysis and intervention. Following a root cause analysis of BH post-emergency department (ED) visit follow-up care for AOD abuse or dependence, FL HHH determined gaps in the following: − ED post-discharge care management and outreach, receipt of discharge communication from the provider, and confirmation of member follow-up within 7 days. − Timely receipt of the Florida Encounter Notification Service (ENS) report to address follow-up care. − Lack of access and availability of follow-up appointments due to staffing shortages resulting from the PHE pandemic. Some members are not linked to a BH provider impacting Access to Care.
b. Describe initiatives implemented based on recommendations: • FL HHH developed interventions to enhance care coordination, education, and member and provider engagement post-ED visit. • FL HHH developed interventions to enhance efforts to obtain real-time ED visit notifications through Florida's ENS. • FL HHH developed interventions to promote telehealth utilization and expansion to address lack of access and availability of appointments.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The *Follow-Up After ED Visit for Substance Use* (FUA) 7-day rate and 30-day rate both exceeded the target for MY2022. Statistically significant performance improvement was achieved for the *Follow-Up After ED Visit for Substance Use* (FUA) 7-day HEDIS measure in MY2022 when compared to the MY2019 baseline. • Data evaluation is ongoing to determine performance improvement for 2023.
d. Identify any barriers to implementing initiatives: • Member outreach barriers include a high population of unable to reach members, and members with invalid phone contact numbers. • Providers fail to include diagnosis on ENS report, causing delays in member identification for outreach. • Staffing shortages following the PHE pandemic and members not being linked to a BH provider continue to impact access and availability of appointments.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue member outreach efforts to improve care coordination, education, and engagement by utilizing resources to access accurate member contact information. • Increase member outreach efforts to improve the effectiveness of discharge planning, TOCs, and post-discharge care coordination by educating and engaging family/caregivers and utilizing resources to access accurate member contact information. • Educate providers on the importance of including proper diagnosis on the ENS report to prevent delays in member outreach. Identify trends with providers and opportunities for intervention.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

- Ensure continued utilization of the daily ENS report to obtain timely notifications of ED visits and track success with member outreach to include in intervention outcomes reporting.
- Continue to educate members and promote scheduling of telehealth appointments to improve timely access and availability to follow-up care.
- Continue quarterly data trending to identify and mitigate barriers, evaluate successful intervention progress, and measure effectiveness on improvement in these areas.

HSAG Assessment

Recommendations for Behavioral Health Domain

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* measure.

Response

a. Describe why this weakness exists:

- In our effort towards continued improvement of members accessing AOD Abuse or Dependence Treatment, data monitoring strategies continuously inform new opportunities for analysis and intervention. Our program is designed to provide services and supporting information to our entire population, recognizing the member level of need, and tailoring our interventions systematically. Following a root cause analysis to determine barriers to members receiving the services related to the *Initiation and engagement of AOD Abuse or Dependence Treatment-Engagement of AOD Treatment-Total* measure, FL HHH determined gaps in the following:
  - Member social determinant of health (SDOH) needs, especially homelessness.
  - Lack of substance use disorder (SUD) treatment options.
  - Privacy regulations that prohibit the sharing of SUD diagnosis without informed consent.
  - The impact of the global pandemic on face-to-face services.

b. Describe initiatives implemented based on recommendations:

- FL HHH collaborates with BH partners to identify members with SDOH needs and high behavioral health (BH) risks.
- FL HHH collaborates with BH partners who utilize internal tools and platforms to provide community resource assistance.
- FL HHH collaborates with BH partners to assess opportunities to partner with community providers to improve access to resources to meet population needs.
- FL HHH collaborates with BH partners to assess network adequacy for SUD treatment options and obtains feedback from community providers on available SUD treatment programs.
- FL HHH collaborates with BH partners to educate BH providers on care coordination between both medical providers and BH providers and between BH providers and SUD providers.
- FL HHH continues to expand telehealth services to meet growing member needs for services.
- FL HHH collaborates with BH partners to educate BH inpatient facilities on the IET measure to address SUD referrals in discharge plans and shares performance and opportunities for improvement.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- For MY2022, the technical specifications for the *Initiation and Engagement of AOD Abuse or Dependence Treatment-Engagement of AOD Treatment-Total* measure changed from a member-based to an episode-based measure. The final rates for MY2021 are not comparable to the final rates for MY2022.
- Data evaluation is ongoing to determine performance improvement for 2023.

d. Identify any barriers to implementing initiatives:

- Transportation needs are more difficult to meet in rural areas and needs for additional transportation for member family members and/or children.
- Homelessness and other SDOH needs impact members' ability to initiate and engage in SUD treatment.
- Lack of formal assessment tools to assess SDOH needs prior to 2022.
- Lack of community knowledge of new SUD treatment programs and opportunities for increased marketing of available SUD treatment programs.
- Members with SUD diagnoses continue with treatment at a lower rate than those with mental illness diagnoses. Members must consent to SUD referrals and may lack insight or may not be ready to initiate SUD treatment.
- Lack of care coordination between inpatient and outpatient providers.
- Internet availability is limited in certain areas and some members prefer face-to-face services.

e. Identify strategy for continued improvement or overcoming identified barriers:

- Continue collaboration with BH partners to utilize the formal assessment tools developed in 2022 to identify and address the specific needs of members with SDOH needs and high BH risks, including members in rural areas with transportation barriers, those with needs for additional transportation for member family members and/or children, and the homeless.
- Continue collaboration with BH partners utilizing internal tools and platforms to provide community resource assistance to members.
- Continue collaboration with BH partners to assess opportunities to partner with community providers to improve access to resources to meet population needs, increase community knowledge of new SUD treatment programs, and opportunities for increased marketing of available SUD treatment programs.
- Continue collaboration with BH partners to assess network adequacy for SUD treatment options and obtain feedback from community providers on available SUD treatment programs.
- Continue collaboration with BH partners to educate on care coordination between both medical providers and BH providers and between BH providers and SUD providers.
- Continue to expand telehealth services to meet the growing service needs of members.
- Continue quarterly data trending to identify and mitigate barriers, evaluate successful intervention progress, and measure effectiveness on improvement in these areas.

HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for LTC Program
HSAG recommended the following: • Evaluate care coordination processes to determine whether there are opportunities to enhance the methods in which the plan engages with members and facilities to support successful discharges to the community. For example, the plan should determine if it is effectively using all available data and information collected during a member's initial facility admission, as well as upon hospital discharges to the facility, so that effective discharge planning occurs. Additionally, the plan should assess whether it has adequate community support in place to facilitate members successfully transitioning to reside in a community setting within 100 days of admission to a facility.
Response
a. Describe why this weakness exists: • In our effort towards continued improvement of care coordination processes of long-term care (LTC) members entering the acute care setting, data monitoring strategies continuously inform new opportunities for analysis and intervention. Our program is designed to provide services and supporting information to our entire population, recognizing the member level of need, and tailoring our interventions systematically. Following an audit to evaluate care coordination processes of LTC members entering the acute care setting, FL HHH identified gaps in the following: − Detailed oversight of members upon admission and transition though an acute care facility. − Adherence to established processes to identify, report and support discharge planning needs of LTC members entering acute care, transitioning to inpatient rehabilitation (rehab) facilities, and ultimately being discharged to their original residential setting.
b. Describe initiatives implemented based on recommendations: • Developed and piloted interventions to enhance person-centered discharge planning, care transitions, and post-discharge care coordination, including member outreach and facility and community support services collaboration strategies.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For measurement year 2020, the *LTSS Minimizing Institutional Length of Stay (MIS)* measure rate was 27.1% and increased to 31.16% for measurement year 2021, exceeding the Florida Statewide rate in both 2020 and 2021. • Improvements were achieved in timely notification of member admission to Nursing Facilities and increase in transitions to a community setting post Nursing Facility discharge. • Data evaluation is ongoing to determine performance improvement for 2023.
d. Identify any barriers to implementing initiatives: • Post the PHE impacts to staffing of Home Health Providers can be a barrier for timely transition for some members. • Inadequate resources of clinician candidates that meet the qualifications to provide services to the population being served.
e. Identify strategy for continued improvement or overcoming identified barriers: • FL HHH will continue to expand the collaborative process pilot to support LTC members through transitions of care and monitor outcomes of these efforts. • FL HHH will continue to identify additional opportunities to improve the monitoring, reporting, and collaboration efforts upon a member's initial admission to the acute care setting.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• FL HHH will ensure there are adequate resources of clinician candidates that meet the qualifications to provide services to the population being served.
HSAG Assessment

Molina-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • Many non-urgent services were cancelled or postponed, leading to delays in preventative and ambulatory care. • Healthcare practice locations experienced closures of certain locations and reduction in staffing levels. • Unable to locate members to assist with scheduling appointments
b. Describe initiatives implemented based on recommendations: • An increase in the number of provider engagements from 10 to 12 per month and on-going member outreach through calling campaigns was reinforced. • Introductions of Molina's Champions Program and a Diabetes Nutrition Counseling referral to broaden member outreach and reminder of annual visits. • Targeted outreach for high-risk members, such as those who have not had an annual visit in two years or more. This collaboration includes efforts from newly contracted vendors to provide in home visits, Healthcare Services, and Case Management to evaluate reasons for abstaining from annual visits. • The AAP measure has been incorporated into Molina's Behavioral Health Provider Pay for Quality program. Providing a financial incentive of $50 for each member seen over the benchmark, with a goal of closing the gap in preventive care and motivating providers to engage in members annual visits
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • An increase in performance was observed following the collaboration of a new vendor assistance program aimed at identifying missing member phone numbers. Out of the 11,391 initially unavailable member phone numbers, 5,695 were successfully located.
d. Identify any barriers to implementing initiatives: • Staffing shortages and the closure of certain provider locations. This placed limitations on the providers effectively collaborating with managed care and providing appointments for the members to be seen. • Inaccurate or incomplete member demographics to outreach and assist them with education and appointment setting
e. Identify strategy for continued improvement or overcoming identified barriers: • Improve our outreach methods by introducing text messaging for convenient engagement with members. • Continue telephonic outreach efforts and educational programs to connect with members and provide valuable information to encourage involvement in their care. • Collaborate with community resources, including local Health Departments, hospitals, and YMCA for the local educational programs offered.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance. In doing so, the plan should consider the nature and scope of the issue (e.g., whether the issues related to barriers such as a lack of patient and provider communication or education).
Response
a. Describe why this weakness exists: • Inaccurate or missing member demographics to successfully outreach after discharge. • Members not adhering to scheduled appointments • Primary Care doctors are unaware of their ability to help close behavioral health gaps in care for their members after discharge.
Describe initiatives implemented based on recommendations: • Molina utilizes daily ENS notifications to follow-up with members identified with an inpatient facility or emergency room discharge. Identified members are assigned to the Care Transitions team and/or assigned care manager for follow-up. Assigned care coordinator or care manager will outreach identified members to assist with scheduling 7 Day follow-up appointments and coordinate transportation if necessary. • Health Educators make six call attempts to members in order to remind them of their upcoming appointment and coordinate transportation.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives: • Member's lack of adherence to schedule appointments, demographic issues contacting 55% of members once discharged from facility due inaccurate contact information. • Inconsistency of hospitals and facilities to discharge members with a prior scheduled appointment.
d. Identify strategy for continued improvement or overcoming identified barriers: • Education to high utilizing Hospitals and Primary Care Physicians/ BH health providers • Introduce outreach methods to include text messaging, offering members a more convenient communication channel with Molina. • Continue to provide telephonic outreach encouraging members to adhere to scheduled appointments and provide education on resources available to them.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for LTC Program
HSAG recommended the following: • Evaluate care coordination processes to determine whether there are opportunities to enhance the methods in which the plan engages with members and facilities to support successful discharges to the community. For example, the plan should determine if it is effectively using all available data and information collected during a member's initial facility admission, as well as upon hospital discharges to the facility, so that effective discharge planning occurs. Additionally, the plan should assess whether it has adequate community support in place to facilitate members successfully transitioning to reside in a community setting within 100 days of admission to a facility.
Response
a. Describe why this weakness exists: • Nursing Facility Admits to community transitions weakness exist because members face many barriers to transition. Some examples are homelessness, low-income, no-income lack of housing, lack of providers, member choice, lack of community resources, no family support, facility does not agree with the transition, etc.
b. Describe initiatives implemented based on recommendations: • We are in the early stages of partnership with the Point Click Care Team that would provide the CMs full chart access to the facilities that used the software. • Molina's Community Connectors assist members with housing needs and additional resources. • Molina's Transition of Care (TOC) program has been designed to focus on coordination and communication during a member's admission and the through the post discharge period. This gives members a single point of contact to assist the member in becoming an active participant in their care, ensuring access to needed care and address SDOH barriers.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): •
d. Identify any barriers to implementing initiatives: • Based on the member's health status, upon return to the community, they may be more at risk for a fall, have challenges managing changes to prescribed medications, experience some side effects of newly prescribed medications, or have dietary changes.
e. Identify strategy for continued improvement or overcoming identified barriers: • Education and training to the CMs on the Point Click Care system. • Continue to provide monthly outreach encouraging members of potential transition. Additionally, participate in case staffing with facility social worker and clinical team.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Methodology
HSAG recommended the following: • Molina-C had opportunities to improve the documentation for performance indicator specifications and administrative data completeness for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. The plans should provide adequate details for HSAG and the Agency to better understand the interventions. For example, the plans should document how they will improve efforts to obtain real-time notifications from Florida's ENS and how the plans will utilize those data. For outreach interventions, the plans should include the mode and frequency of outreach.
Response
a. Describe why this weakness exists: • Coordinating time-sensitive care following discharge.
b. Describe initiatives implemented based on recommendations: • Molina utilizes daily ENS notifications to follow-up with members identified with an inpatient facility or emergency room discharge. Identified members are assigned to the Care Transitions team and/or assigned care manager for follow-up. Assigned care coordinator or care manager will outreach identified members to assist with scheduling 7 Day follow-up appointments and coordinate transportation if necessary. • Six call attempts are made to members in order to remind them of upcoming appointments, coordinate transportation and offer Telemedicine appointments to increase seven-day compliance. • Monthly provider engagements are conducted to address the opportunity of closing the seven-day gap, targeting groups with members who missed the window of a follow-up appointment, provide education to Primary Care Physicians on Telehealth alternatives.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • FUA (19.64%) exceeded both the baseline rate and the mandated goal during CY 2022.
d. Identify any barriers to implementing initiatives: • Member's lack of education regarding follow-up appointments. • Difficulty outreaching all identified members due to lack of current demographic information • Lack of Primary Care Physicians' awareness about their ability to close gap for members discharged from the Emergency Department
e. Identify strategy for continued improvement or overcoming identified barriers: • Molina will continue to expand the ENS notifications to initiate outreach as soon as members are identified in order to facilitate access to seven-day follow-up appointments. • Continue monitoring our efforts in educating Providers on appropriate discharge planning protocols, utilization of Telehealth alternatives to further address and close the seven-day gap efficiently.
HSAG Assessment

Simply-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • There are various challenges as it relates to improving member utilization of preventive and ambulatory services. The Plan is working on expanding network access, educating members on the importance of preventive care, and educating both members and providers on the use of Telehealth. The Plan also continues to see an increase in its eligible population which creates an additional challenge to seeing continuous improvement.
b. Describe initiatives implemented based on recommendations: • To address Adults' Access to Preventive/Ambulatory Health Services (AAP), Simply Healthcare Plans (SHP) has implemented multiple initiatives including: Provider-Level • Collaborating with providers on targeted clinic sessions • Hold monthly collaborative meetings with priority groups to share and review data. • Conduct a workgroup with our Provider Relations partners to review data and identify members with the largest non-compliance in their panel to explore barriers • SHP regularly identifies and engages the top providers that have the largest number of AAP care gaps monthly. • SHP provides those groups with rates and member care gap lists as needed. • Enhanced to distinguish new vs established patients • Provider Education on Telehealth is ongoing • Covers all approved modalities − Live Video − Store and Forward − Remote Patient Monitoring • Patient-Centered Medical Home (PCMH) Incentive Program • The Plan increased provider education towards appointment access and availability standards and requirements • The Plan is conducting live and on-demand trainings to provider office staff and appointment schedulers to increase awareness and education towards appointment availability and alternate methods of access to care such as Telehealth, other providers, and alternate locations, expanding member awareness on access to care options when their provider is unavailable. • The Plan conducts analysis of the quarterly appointment wait times report to identify non-compliance trends, outliers by provider type. • Provider outreach to address access to care limitations and non-compliance reported in the Wait times report

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

System-Level

- Through the use of a new supplemental database, the Plan has improved the completeness and accuracy of its claims/encounters received from urgent care facilities

Member-Level

- Engaging members to attend targeted clinic sessions
- Conduct outreach to members with open care gaps
- Facilitate member education regarding services available in an effort to engage with their Primary Care Physician (PCP) and promote completion of preventive screenings
- Assist members in scheduling appointments and eliminate barriers to attending appointments
- To educate and encourage members to use Telehealth, Simply Healthcare Plans has implemented the following initiatives:
  - Live Health Online – ability for members to video chat with PCPs and Urgent Care doctors 24/7
  - Behavioral Health (BH) – ability for members to video chat with Behavioral Health providers 24/7
- Ongoing text campaigns tailored for AAP
- The Plan also incorporated dedicated workgroups focused on access to care issues and member complaints.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Year over Year improvement seen in Appointment Wait Times
- Year over Year Improvement in the Plan's Access and Availability rates
- Enhanced communication between the Plan and its Provider network with regards to member-related and access to care issues.

d. Identify any barriers to implementing initiatives:

- Continuing to see an increase in the Plan's eligible population which impacts rate of compliance
- Staff turnover in provider offices affecting education and awareness towards Healthcare Effectiveness Data and Information Set (HEDIS) measures
- Provider schedules are often overbooked, impacting the availability for members to schedule appointments when needed
- Transportation-related barriers
- Continuing to monitor the accuracy of our provider network/directory, supported through the use of secret-shopper activities

e. Identify strategy for continued improvement or overcoming identified barriers:

- Monthly deep dives into provider panels are conducted
- Continue to track all AAP initiatives monthly with key stakeholders to review and analyze intervention and outcome data in order to determine improvement progress.
- The Plan has reinstated and has increased the frequency of its Enrollee Advisory Committees to better incorporate enrollee feedback.
- Continue to work with and educate our provider network.
- Continue current efforts towards improving appointment availability and stressing the importance internally and among the provider network.

HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Identify best practices for ensuring adolescents receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of adolescents not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.
Response
a. Describe why this weakness exists: • Among the various challenges to improving rates of adolescents who receive medically appropriate vaccinations include an overall lack of commitment and/or hesitancy. The Plan continues to work on providing members and providers education on the importance of preventive care, including appropriate vaccinations.
b. Describe initiatives implemented based on recommendations: • Member Focused Efforts: − Educating providers on newly recommended age guidelines for immunizations such as Human Papillomavirus (HPV) − Healthy Behaviors Member Incentive – HPV Series completion − Direct-to-Member Outreach o Text campaigns, Interactive Voice Response (IVR), email, social media o Back to School Readiness events o Flu Season and Immunization Drive-Ups o Appointment scheduling assistance with PCP o Promoting education and access to incentives as part of the Benefits page and Patients portal − Clinic Sessions o Targeted outreach encouraging all recommended vaccinations o Clinic session attendees incentivized for attendance/closing care gap during session − Provider Education and Collaboration o Provider Bulletins ▪ Updated annually per guidance on coding & reimbursement rates ▪ Distributed to PCPs and Specialists via fax ▪ Email & Provider website postings completed o Data Sharing ▪ The Plan sends providers lists of member in their panel who are due for a vaccination within 120 days − Cobranding opportunities to their patients for education about schedule of preventive visit and immunizations − Pharmacy Communications − Clinic Session Collaboration o Worked with Providers to host specific clinic days for pediatric vaccinations o Provider Flu Trainings conducted o Continuing Medical Education (CME) credits are offered to participants

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Year Over Year improvement seen in the Plan's HPV rates
d. Identify any barriers to implementing initiatives: • Increased hesitancy towards immunizations • Adolescent refusal/lack of commitment to go to the doctor • PHE Impact: − It is difficult to ascertain the impact of the PHE on these rates. The overall impact of the pandemic, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from further improving its rates of immunizations/vaccines.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Plan has seen encouraging results from these efforts and will continue to meet with key stakeholders monthly to review the progress and effectiveness of each intervention • Continue member and provider education efforts
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure (both indicators).
Response
a. Describe why this weakness exists: • Adults and adolescents may not recognize the need or readiness to change in terms of their substance use. • Denial is often the first response to the new a new Substance Use Disorder (SUD) treatment episode. Adults and Adolescents feel they completed their treatment and fail to see the benefit of follow-up. • Members are not motivated to seek follow-up treatment until they recognize the problems in their life created by their alcohol and/or drug use. Often, this is not after the first SUD episode. • Social Determinants of Health (SDoH) impact member's ability to stay in treatment or stay focused on sobriety goals if there are risks such as lack of housing or food insecurity. • Members experiencing homelessness may not have updated contact information and the health plan may not have a good phone number or address to contact them. • Inappropriate admissions due to law enforcement initiating a Baker Act admission. Baker-Acted individuals are often less likely to comply with follow-up.
b. Describe initiatives implemented based on recommendations: • The Plan uses Encounter Notification Service (ENS) data through a vendor that comes in daily to identity facility admissions. We review for SUD Diagnoses and outreach the member if not already assigned a Case Manager (CM). We call on all Emergency admissions identified on the ENS report. • If there is a lack of a current phone number, we review previous claims or contact recent providers to obtain updated contact information. • The CM refers the member to a Certified Community Behavioral Health Clinic (CCBHC) when possible • The CM can provide resources to address Social Determinants of Health issues such as homelessness.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• The Plan may enroll members in its Healthy Behaviors program where members are rewarded for treatment compliance.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Year-Over-Year improvement seen in the Plan's Initiation Phase metric • Better and quicker identification of members with SUD diagnoses through the use of ENS
d. Identify any barriers to implementing initiatives: • Member readiness to change and motivation to continue their AOD treatment. • Emergency Department (ED) data is not being received by the Plan timely • Emergency Department's initial diagnosis may not include SUD, this creates an initial delay in identifying/engaging these members
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to work with the ENS vendor and facilities to ensure SUD diagnoses are appropriately identified. • Educate Medical and BH providers on IET measure and on the HEDIS specifications to encourage timely follow-up appointments.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • Through its behavioral health workgroup, the Plan determined that a significant portion of behavioral health facilities do not utilize the Florida Encounter Notification Service (ENS). As such, this results in a delay in notification of behavioral health discharges for follow-up. In addition, lack of access and availability of behavioral health appointments creates challenges.
b. Describe initiatives implemented based on recommendations: • SHP continues to evaluate existing programs and implement pilots in alignment with Agency-led Statewide collaborative efforts Provider-Level: • Bi-weekly interdepartmental meetings with BH partner • Provider webinars for Telehealth expansion • Incorporated BH Telehealth information into PCP toolkit • Pay-for-Performance Offering – Provider upside incentive model to support follow-up after hospitalization for mental illness • Offering home-based therapy appointments for high-risk members • Continued education on BH services available through the Plan Member-Level: • Promotion of BH Telehealth (Video and Telephonic) throughout the Plan membership • FAQs on web print promoting BH Telehealth

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• All members who participate and complete a TH visit are offered 1 week of free meals as a way to incentivize participation • Member Incentive program for FUH 7-Day and 30-Day Follow-Up • Completion of a new Follow-Up After Discharge form • Ongoing text campaign targeting members for a 7- and 30-day follow-up visit once a behavioral health-related event in the ED or Hospital is identified • Mental Health Toolkit containing various resources and education • Health Risk Assessment (HRA) BH Focus – members identified as having BH needs on the HRA are prioritized for outreach to ensure all member needs are appropriately addressed • Aftercare Program - Outreach to recently discharged members • Ensure follow-up appointment is scheduled within 7- and 30-days post discharge • Assess post discharge needs • Provide referrals (if needed) • Address barriers to appointment compliance • Provide member education System-Level: • ENS Notification Enhancements − Customized alerting for all Behavioral Health-related measures
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Statistically significant improvement is seen in the Plan's HEDIS FUH rate when comparing MY 2022 to MY 2021 • Improved coordination of care • A faster and more efficient data exchange process resulting in faster and more effective follow-up care. • Improvement in Access and Availability for Providers
d. Identify any barriers to implementing initiatives: • Lack of timely identification of members with a psychiatric Hospital/ED event • Lack of member incentive to see a BH provider within 7 and/or 30 days of discharge • Socio-economic factors (i.e., homelessness, lack of contact information, etc.) • PHE Impact: − It is difficult to ascertain the impact of the PHE on these rates. The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from potentially exceeding its annual goals for HEDIS
e. Identify strategy for continued improvement or overcoming identified barriers: • Continued provider and member education • Further promote and expand on the use of Telehealth • Continue to find creative ways to incentivize members to follow-up with a BH provider within 7 days of ED/Hospital event • Continue to address and mitigate any barriers identified through ongoing monitoring and evaluation • Continue to analyze the impact of interventions implemented through the Plan-Do-Study-Act (PDSA) process
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for LTC Program
HSAG recommended the following: • Evaluate care coordination processes to determine whether there are opportunities to enhance the methods in which the plan engages with members and facilities to support successful discharges to the community. For example, the plan should determine if it is effectively using all available data and information collected during a member's initial facility admission, as well as upon hospital discharges to the facility, so that effective discharge planning occurs. Additionally, the plan should assess whether it has adequate community support in place to facilitate members successfully transitioning to reside in a community setting within 100 days of admission to a facility.
Response
a. Describe why this weakness exists: • While this is a weakness statewide, this was not identified for SHP's Long-Term Care (LTC) Program. The program's observed rates for this measure have been consistently greater than it's expected rate for the last 3 years. However, identification of members can be a challenge as well as timely assessment.
b. Describe initiatives implemented based on recommendations: • To ensure timely identification of members that have transitioned after a short-term institutional stay have the services needed to remain in the community, case managers (CMs) review: − Census reports and internal discharge reports • For members on the inpatient dashboard, the Team Leads (TLs) are to check the member record for the 5 day significant change visit. If it has not been scheduled/completed, the TL creates the task and alerts the assigned CM. • A significant change assessment within 5 days of an inpatient discharge. • For members that go into a skilled nursing facility post hospital discharge, CMs: − Conduct significant change assessments within 5 days of discharge, and visit weekly
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • MY2021 rate of 31.92% is the highest among its competitors and 1.16 percentage points higher than MY2020.
d. Identify any barriers to implementing initiatives: • The LTC Program may not identify members timely for which the plan is not the primary payor. • Increase in membership over projected rates and CM attrition has resulted in continuous hiring of new CMs and their respective learning curves.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Quality Department meets with the LTC program management staff on a weekly basis. We go over rates and look into any areas-of-concern to identify trends-and-patterns and then come up with a plan to address any lower-performing areas.
HSAG Assessment

Sunshine-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of preventive and ambulatory services due to the fear of exposure.
b. Describe initiatives implemented based on recommendations: • Sunshine Health is promoting member utilization of a 24/7 telemedicine program through the Teladoc health app. Members will be mailed a flyer promoting Teladoc use once the flyer has received AHCA approval. • The Concierge Team calls members with care gaps and helps them schedule appointments.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None Identified.
d. Identify any barriers to implementing initiatives: • Some members may not have access to smart phones or devices. • Bad addresses due to frequent residence changes. • Member no-show rates are high after appointments are made.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management assists with scheduling medical appointments, as appropriate. • MyHealthDirect is utilized to enhance efforts to schedule preventive health appointments. • Sunshine Health continues work to expand network access to Urgent Care and Minute Clinics.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Identify best practices for ensuring adolescents receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of adolescents not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of preventive and ambulatory services due to the fear of exposure.
b. Describe initiatives implemented based on recommendations: • Immunization Tool Kit - Small practices with decent member volumes but poor vaccine compliance rates were targeted to receive the Immunization Tool kit in 2022. The Quality Practice Advisor (QPA) team met with these practices and assisted with identifying a vaccine champion in the office, posting vaccine policies, and preparing a vaccine tool kit (this kit included resources from the CDC, Pfizer, Merck, and the American Cancer Society). The office was also assisted to create an alert system for vaccines that were due and the QPA met monthly with the vaccine champion to ensure measures were implemented. • Shoes for Shots (aka Healthy Steps Program) - Partnered with Community Medical Group (CMG) to provide free shoes and backpacks to kids who came and received vaccines. CMG advertised the event via email, radio, posters, social media, and tv ads.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Of the 22 practices that were targeted for the Immunization Toolkit: 20 practices improved CIS Combo 3, 17 practices improved for CIS Combo 10, 19 practices improved for IMA Combo 1, and 19 practices improved for IMA Combo 2. • Shoes of Shots: Almost 200 members received vaccines.
d. Identify any barriers to implementing initiatives: • Immunization Tool Kits: 2 practices lacked baseline data to determine change. • Shoes for Shots: Since members did not have to RSVP, the shoe size had to be obtained, and members had to return a week later to pick up the shoe order.
e. Identify strategy for continued improvement or overcoming identified barriers: • If Shoes for Shots is continued, additional organizational partnerships will be explored.
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. Analyze data and consider whether there are disparities within the plan's populations that contributed to lower access to care. Upon identification of a root cause, implement appropriate interventions to improve quality of, access to, and timeliness of prenatal and postpartum care.
Response
a. Describe why this weakness exists: • Providers are incorrectly coding positive pregnancy tests. • Members aren't aware of pregnancy or hide pregnancy from parent/guardian until late in prenatal care. • Members are not returning for postpartum care because they do not understand the importance.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • OB/GYN Incentive Program to incentivize OB/ GYNs for each care gap they close. • Utilization of OB Care Gap Report to conduct targeted member and provider education. • Quality Practice Advisors conduct virtual and in-person Provider visits to educate and improve prenatal and postpartum care rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS PPC-Pst measure rate increased from 66.18% for CY 2021 to 71.78% for CY 2022. • The HEDIS PPC-Pre measure rate increased from 72.99% for CY 2021 to 78.59% for CY 2022.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why women are not receiving breast cancer screenings. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving breast cancer screenings.
Response
a. Describe why this weakness exists: • Lack of transportation to mammography screening. • Fear of bad news or pain from the mammogram. • Lack of a recommendation from a health care provider to get mammography screening.
b. Describe initiatives implemented based on recommendations: • Contracted with 3D Mobile Mammography to provide mobile Mammograms. • OB/GYN Incentive Program to incentivize OB/GYNs for each breast cancer screening care gap they close. • Quality Practice Advisors conduct virtual and in-person Provider visits to educate providers and improve breast cancer screening rates. • Members receive MyHealthPays reward of $20 for completing an annual Mammogram Screening.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS BCS measure rate increased from 46.34% for CY 2021 to 49.39% for CY 2022.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes and implement appropriate interventions to improve performance of all five *Comprehensive Diabetes Care* measure indicators.
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of MD offices due to the fear of exposure. • Endocrinologists did not have visibility into the care gaps of the members they were seeing. • Member noncompliance due to competing personal demands.
b. Describe initiatives implemented based on recommendations: • Endocrinology Incentive Program initiated in March 2023 to incentivize providers for closing care gaps. • Members receive MyHealthPays reward of $25 for completing annual Comprehensive Diabetes Care. • Utilization of Care Gap Report to conduct targeted member and provider education. • Quality Practice Advisors conduct virtual and in-person Provider visits to improve rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment • NA, no results available at time of reporting.
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.
Response
a. Describe why this weakness exists: • Follow-up visits are not scheduled before member leaves ED. • Member refusal. • Not a perceived problem by member family. • Member readmission.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

b. Describe initiatives implemented based on recommendations:
- Case Management follow-up with member after ED visits for mental illness or AOD abuse or dependence to help schedule follow-up care.
- BH provider care gap reports.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- The HEDIS FUA measure increased from 5.73% for CY 2021 to 15.07% for CY 2022.
- The HEDIS FUM measure increased from 26.09% for CY 2021 to 27.58% for CY 2022.

d. Identify any barriers to implementing initiatives:
- Members contact information is sometimes not correct.
- Members do not answer phone or return messages.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Case Management makes multiple attempts to contact member and a letter is mailed to the member when unable to reach.

HSAG Assessment

Recommendations for Behavioral Health Domain

HSAG recommended the following:
- Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure (both indicators).

Response

a. Describe why this weakness exists:
- Member refusal.
- Not a perceived problem by member family.
- Stigma of mental health care.

b. Describe initiatives implemented based on recommendations:
- The Concierge Team calls members with care gaps and helps them schedule appointments.
- Behavioral Health Incentive Program initiated in March 2023 to incentivize providers for closing care gaps.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended.

d. Identify any barriers to implementing initiatives:
- Incorrect member contact information.
- Member no-show rates are high after appointments are made.
- Provider incorrect coding.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Case Management assists with scheduling medical appointments, as appropriate.
- Continued provider education by Quality Practice Advisors.

HSAG Assessment
- NA, no results available at time of reporting.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • Follow-up visits are not scheduled before member leaves inpatient facility. • Member refusal. • Not a perceived problem by member family. • Member readmission.
b. Describe initiatives implemented based on recommendations: • Case Management follow-up with member after hospitalization for mental illness to help schedule follow-up care.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS FUH measure increased from 22.94% for CY 2021 to 28.83% for CY 2022.
d. Identify any barriers to implementing initiatives: • Members contact information is sometimes not correct. • Members do not answer phone or return messages.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management makes multiple attempts to contact member and a letter is mailed to the member when unable to reach.
HSAG Assessment
Recommendations for LTC Program
HSAG recommended the following: • Evaluate care coordination processes to determine whether there are opportunities to enhance the methods in which the plan engages with members and facilities to support successful discharges to the community. For example, the plan should determine if it is effectively using all available data and information collected during a member's initial facility admission, as well as upon hospital discharges to the facility, so that effective discharge planning occurs. Additionally, the plan should assess whether it has adequate community support in place to facilitate members successfully transitioning to reside in a community setting within 100 days of admission to a facility.
Response
a. Describe why this weakness exists: • LTC population has frequent hospital admission which result in Rehab discharges. • Nursing home facility providers will often convert members to a Custodial Admission when Medicare coverage ends. • LTC population is older and more fragile.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • Improve partnership with facilities to provide more support for successful transitions by getting facility to do more on front end. • Created partnership with Centers for Independent Living (CILS) to help support successful transitions to the community • Nursing home diversion program that focuses on care transitions between Inpatient settings (hospitalization, rehab and custodial). • Admission, Transfer, and Discharge (ADT) data pushed to Care Coordinators daily for follow-up. • Conduct nursing home audits for every new nursing home member enrollment to identify transition opportunities.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • None Identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment • NA, no results available at time of reporting.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Assessment
HSAG recommended the following: • In Step 9 (Assessment of Improvement Achieved) of the PIPs, Sunshine-C was unable to achieve any improvement for the Administration of the Transportation Benefit PIP. For unsuccessful interventions, the plans should make data-driven decisions to revise the current intervention or discontinue it and implement new interventions. • The plans should consider using QI science tools such as process mapping, FMEA, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small scale using PDSA cycles should be ramped up and adopted planwide in order to impact the entire eligible population.
Response
a. Describe why this weakness exists: • No weakness was identified because the Administration of the Transportation Benefit PIP rate did increase from CY 2020 to CY 2021.
b. Describe initiatives implemented based on recommendations: • Sunshine Health's QI staff are already trained in QI methodology, such as barrier analysis, root cause analysis, and the Plan-Do-Study-Act (PDSA) improvement cycle. The QI team, in conjunction with dedicated, cross-functional workgroups and the Performance Improvement Team, completed a causal barrier analysis using appropriate quality improvement tools, such as a Fishbone diagram, to assist in the identification of barriers, contributing factors, and potential risks. Based on identified barriers, interventions are developed and implemented for the next re-measurement period. Subsequent re-measurement periods are established to assess the effectiveness of the interventions. • Create survey to obtain member feedback to better understand member-related barriers related to access to care.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Sunshine Health Administration of the Transportation Benefit PIP rate increased from 88.25% for CY 2020 to 91.08% for CY 2021.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment

United-C

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why enrollees do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with enrollees to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • Enrollees are hard to reach - ~30% of enrollees have no phone number, many with history of non-compliance (some with multi-year), and otherwise healthy adults do not go to the Provider for a wellness visit.
b. Describe initiatives implemented based on recommendations: • Acceptance and abstraction of supplemental data via Practice Assist (Provider portal), an effort to capture medical record data not otherwise closed via a claim. A year-end Provider incentive (pay for performance) on Adults' Access to Preventive/Ambulatory Health Services (AAP), per gap closure (focused on enrollees with co-morbidities) for Providers with largest volume of non-compliant enrollees. Enrollee outreach calls to select cohort of enrollees with co-morbidities (diabetes, high blood pressure). Interactive Voice Response (IVR) Telephonic Outreach for AAP, Diabetes Care, and Women's Health. "Feet on the Street" enrollee outreach focused on enrollees with Social Determinants of Health (SDoH) needs and care gaps.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None noted - too early to evaluate, need initiatives to mature to demonstrate influence on AAP rate and to allow time for claims runout.
d. Identify any barriers to implementing initiatives: • Enrollees are hard to reach - ~30% of enrollees have no phone number, many with history of non-compliance (some with multi-year), and otherwise healthy adults do not go to the Provider for a wellness visit. Redetermination impact on enrollees - compliant enrollees did not re-enroll.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continued monitoring and evaluation of current tactics and workflows. Working on a telehealth option to be deployed in coming year.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Identify best practices for ensuring children and adolescents receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children and adolescents not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Response
a. Describe why this weakness exists: • "Centers For Disease Control (CDC) data indicates that kindergarten vaccination coverage has steadily declined for all vaccines over the past two school years from 95% to 93% nationally and by as much as 10% in some jurisdictions. This is the lowest that we've seen kindergarten routine vaccination coverage drop nationally in the last decade.".https://www.cdc.gov/vaccines/events/downloads/CDC-Renewed-Call-to-Action-Providers.pdf • The Florida Department of Health September 2023 Vaccine-Preventable Disease Surveillance Report states "The proportion of children aged 4–18 years with new Religious Exemptions (RE) are increasing each month. Statewide, the estimated prevalence of REs among children aged 4–18 years old is 5.3% with individual counties ranging from 1.0–12.1%. The report also states, "The rate of religious exemptions is higher than the rate presented in this report. This is due to eligible persons with religious exemptions who have opted out of Florida SHOTS and persons who have had their religious exemptions processed outside of the Florida SHOTS system." • Region B was identified as having lower immunization rates. Former Region 3 was identified as having the lowest Childhood Immunization Status (CIS) Combo 3 rate and former Region 4 having the lowest Immunizations for Adolescents (IMA) Combo 1 rate. The Florida Department of Health September 2023 Vaccine-Preventable Disease Surveillance Report shows Volusia, Flagler, and St. John's Counties in Region 4 had highest RE prevalence in children ages 4-18 years—6.1% - 12.1%--which may contribute to the lower IMA performance in this region. http://www.Floridahealth.gov/VPD
b. Describe initiatives implemented based on recommendations: • **Enrollee Initiatives:** − Live calls to parents/enrollees that have not yet completed their recommended Child Health Check-Up Visits to assist with appointment scheduling and transportation. − Interactive Voice Response (IVR) calls to remind parents/enrollees who are due for immunizations. − Monthly preventative letters sent prior to the enrollee's birthday reminding them to schedule a well child visit/immunizations. − Enrollee Rewards program offers a gift card incentive to enrollees completing recommended Immunizations for Adolescents. − Pfizer Sponsored Immunization Program. • **Provider Initiatives:** − To reward Providers for bringing children and adolescents up to date with well visits and immunizations, Providers receive an incentive for any closed care opportunity addressing the measures IMA, Well-Child Visits in the First 30 Months of Life (W30), and Child and Adolescent Well-Care Visits (WCV) 12-17 years. Additionally, the incentive amount increases as the Provider meets or exceeds the target score. − Provider Quality Managers conduct monthly virtual meetings with Providers to share Patient Care Opportunity Reports (PCOR), review progress to goal, and offer best practice guidance. Monthly emails are sent to Providers with lists of enrollees who will be reaching age 2 (CIS) and age 13 (IMA) within the next three months that are not up to date with vaccinations. Providers are requested to prioritize outreach to these enrollees and ensure they are compliant before aging out of these immunization measures. − Providers were educated on the importance of entering historical immunization records in Florida Shots when they receive transferred medical records or parents provide record of previous immunizations that are not in Florida Shots.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
− Community Outreach Representatives and Provider Quality Managers provided education and shared best practice messaging during Provider encounters. Some talking points and best practices shared with Providers are below: o **April 2023--National Infant Immunization Week is April 24–30.** We want to highlight the importance of protecting children two years and younger from vaccine-preventable diseases. The CDC and the American Academy of Pediatrics recommend that children stay on track with their well-child appointments and routine vaccinations. On-time vaccination is critical to provide protection against potentially life-threatening diseases. CDC link shared with Providers: https://www.cdc.gov/vaccines/events/niiw/index.html o **April 3rd - 7th is Adolescent Immunization Action Week!** Please help to ensure that adolescents are up to date with recommended vaccines prior to their 13th birthday! Adolescents are attending school and activities with lower vaccine protection than in the past. Many routine immunizations remain below 2019 levels, leaving adolescents susceptible to vaccine-preventable illnesses. Parents cite their child's doctor as the most trusted and influential source of vaccine information. Parents depend on you for vaccine recommendations, addressing questions, and correcting misinformation. Here are suggested actions: ▪ Use your UHCCP Florida Patient Care Opportunity Report to identify adolescents turning 13 years of age three months out that are not yet compliant for their adolescent vaccines and contact them to schedule. ▪ Contact families who have missed well visits/immunizations. ▪ Check vaccination status during all adolescent visits. Deliver confident, concise, and consistent (3Cs) vaccine recommendations. ▪ Make vaccination scheduling convenient—after school, after hours and weekends. ▪ CDC link shared with Providers: https://www.cdc.gov/vaccines/events/AIAW.html • **July/August—2023/24 Back to school Routine Immunization Catch-Up—Take action to get kids' vaccinations on schedule!!** This is a crucial time to communicate with families about vaccinations. − Send reminders to families whose children are due or behind on well-child visits and routine vaccinations. − Offer vaccination only appointments or walk-in vaccinations. − Implement a system for all staff to review vaccination status at every visit or encounter. Build alerts into Electronic Health Record that notify all staff if a patient is due for a vaccine. − Use every visit as an opportunity to recommend and administer all vaccines that are due. − Have standing orders for vaccinations. − Provide strong vaccination recommendations. Stop Measurement about vaccines. − CDC links shared with Providers: CDC-Renewed-Call-to-Action-Providers.pdf https://www.cdc.gov/vaccines/partners/routine-immunizations-lets-rise.html
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Measurement Year (MY) 2022 CIS Combo 3 performance rate increased 4.6% from MY 2021 • Measurement Year (MY) 2022 IMA Combo 1 performance rate increased 2% from MY 2021
d. Identify any barriers to implementing initiatives: • See a. above. Increased prevalence of religious exemptions. • Parents opting out of Florida SHOTS may result in difficulty accessing immunization records. • Incomplete vaccination records—Providers fail to enter historical immunization records in Florida Shots that they did not administer.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Parents only want school required vaccines. • Access to accurate health information—parents with limited health literacy receiving misinformation about vaccines and concerns about safety may result in reluctance to get recommended vaccines for their children.
e. Identify strategy for continued improvement or overcoming identified barriers: • Track bi-monthly Childhood Immunization Series (CIS) and Immunizations for Adolescents (IMA) rates, identifying Providers that are not reaching performance targets for prioritization by Provider Quality Manager focused meetings to assist with root cause analysis and recommendations for improvement. • Community Outreach Representatives and Provider Quality Managers will continue to deliver monthly messaging to Providers on immunization best practices and strategies for improvement. • Provider Quality Managers will assist Providers with enrollee outreach by delivering monthly prospective reports of enrollees due for immunization within the next 3 months.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine barriers to children and adolescents newly started on antipsychotic medications without a clinical indication receiving psychosocial care as first-line treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total.*
Response
a. Describe why this weakness exists: • Although we observe improvement in this rate, we have continued to see through the root cause analysis that some of the prescribers have been falling into this metric year over year. Lab testing improved 2.75 percentage points from 2021 to 2022.
b. Describe initiatives implemented based on recommendations: • The top 10 prescribers in the state were outreached in 2021 to discuss and educate on the technical specifications related to this metric and best practices when prescribing antipsychotics to children. Additionally, data was shared with the prescribers including the children who had not yet had lab testing before the fourth quarter. We encourage the providers to put flags on the charts of those patients to assist in having the lab work ordered when the member returned for an appointment. We have provided additional education in meetings with primary care practices in an effort to encourage primary care to collaborate with behavioral health providers and vice versa. Genoa pharmacy programs focused on medication fills and member outreach, performance feedback for primary care (via PCOR), provider incentives for primary care, and Provider education for BH and medical prescribers are ongoing interventions as well email blasts to behavioral health providers with information on this metric and best practices. Email blasts were sent in August 2022 and August 2023 with an emphasis on this metric and coordination of care with primary care.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable • Lab testing improved 2.75 percentage points from 2021 to 2022. We are already seeing an improvement in 2023 with over four percentage points increase since 2022.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
d. Identify any barriers to implementing initiatives: • It has been difficult to get providers to engage in both behavioral and medical sides. Providers have been expressing that the prescriber should own the responsibility of the lab work. We are working to encourage coordination of care between behavioral and medical provider in an effort to have the children have their lab work completed. In the event lab work indicates a need for intervention, the medical provider would be treating the medical diagnosis. Another barrier is possibly parents not having the proper education on the need for metabolic testing and potential barriers caregivers may face to getting children to get lab work completed compared to the adult population.
e. Identify strategy for continued improvement or overcoming identified barriers: • We have been considering some additional education in 2024 with providers nad caregivers of those children prescribed antipsychotics. We may be incorporating additional education through behavioral health and medical case managers when follow-up phone calls occur with the caregivers of this population post discharge from inpatient level or care, visibility through the PCOR, and also when a member is prescribed an antipsychotic medication.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why enrollees who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for enrollees with BH needs.
Response
a. Describe why this weakness exists: • The Plan's rates for the metrics related to follow-up after an enrollee visits the hospital or emergency department (ED) for mental health (MH) or alcohol or other drug (AOD) abuse or dependence fell below the measurement year (MY) 2021 minimum performance target. The two metrics related to follow-up after an enrollee visits the hospital or ED for mental health or AOD abuse, or dependence are 1) Follow-Up After ED Visit for Mental Illness (FUM) and 2) Follow-Up After ED Visit for AOD Abuse or Dependence (FUA). Although we observe improvement from MY 2021 to MY 2022, FUM and FUA rates continue to fall below the HEDIS 50th percentile. Some of the barriers we continue to observe include enrollees who visit the ED for mental health or AOD abuse believe they do not need follow-up care; for example, most of the AOD abused related visits are due to alcohol use which enrollees may not believe it is an issue or it is a one-time event. We continue to encounter barriers that impact the effectiveness of some of our initiatives, for example, low completion rate of diagnosis in Admissions, Discharge, Transfer (ADT) notifications through the Encounter Notification Service (ENS) which impacts our ability to identify ED visits due to MH and therefore we cannot engage enrollees in care coordination. Due to privacy law restrictions, we are still not able to receive ADT notifications on AOD abuse related ED visits via the ENS. In regards telehealth, we often hear that enrollees do not feel comfortable having a telehealth visit and prefer in-person visits (feedback from Care Advocate team). We have also run into barriers engaging the ED facilities. Most are not easy to engage in conversations around closing FUM/FUA gaps in care. We continue to observe access issues in rural areas in regions 3 and 4.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • United Healthcare Florida has expanded its telehealth Provider network in the last couple of years. From 2019 to 2022 UHC/Optum obtained a 981% increase in telehealth Providers in its network. As of October 31, 2023, UHC/Optum has a total of 2,539 individual Providers that have telehealth capabilities. In addition, our case management teams use a telehealth partner Brave Health to connect enrollees with recommended 7-day follow-up care. In 2023, our behavioral health (BH) leadership (Optum) has worked collaboratively with our telehealth partner to improve their internal structure so they can streamline how they are working with our enrollees. Our team has collaborated with them to improve many of the processes to work with Case management to see these enrollees within 7 days. • Our Quality team continues to educate Primary Care Providers (PCPs) in regard Screening, Brief Intervention, Referral and Treatment (SBIRT) best practices. Telehealth has been included in SBIRT education as a resource for referral and treatment of AOD abuse disorders. They reinforce to Providers that telehealth visits meet the criteria to close Follow-Up After Emergency Department Visit for Mental Illness and Follow-Up After Hospitalization Visit for Alcohol and Other Drug Abuse or Dependence HEDIS gaps. We have connected Providers to our telehealth partner. Our quality team has shared the Live and Work Well website that PCPs can use or refer enrollees to find BH Providers including those with telehealth capabilities. • In 2023 United began a series of meetings with behavioral health discharging facilities that focus on the FUH (Follow-up after Hospitalization for Mental Illness) and FUM/FUA metrics (for those with ED departments). During the meetings we engage the facilities in discussion around barriers organization may be facing to get individuals an appointment prior to discharge, introduce benefits they may not be aware of, and partnering with facilities to link enrollees to those benefits. During those meetings we are promoting telehealth, specifically introducing them to our telehealth partner to address any issues with accessibility.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We observed improvement in both FUM (7-day) and FUM (30-day). We observed a small improvement in FUA (7-day). The most notable change in performance from MY2021 to MY 2022 was observed in FUM (7-day). United FUM (7-day) rate improved by 12.5% from MY 2021 (26.32%) to MY 2022 (29.62%). FUM (30-day) improved by 1.6% from MY2021 (41.61%) to MY2022 (42.29%). FUA HEDIS specifications changed in 2022 leading to a significant increase in FUA performance. Year over year comparison is not valid. Using the HEDIS quality compass we observed that the final FUA (7) rate for MY22 (17.02%) was closer (diff of 0.36) to HEDIS 25th percentile (17.38%) compared to MY 2021 where United performance was 5.04% and HEDIS 25th percentile was 6.34% (diff of 1.30). This shows a steady increase in the FUA (7) performance. Improvement in these metrics is a result of the combined efforts implemented by the United/Optum teams.
d. Identify any barriers to implementing initiatives: • Improving communication with facilities can be challenging. Our Optum BH team has worked to engage facilities through the Provider advocates group. Our BH executive director works to build relationships with facilities as well. Part of the task is to identify the right contacts at the facilities such as discharge facility leaders and discharge planning staff. For those facilities that have participated in meetings, specifically, our Case Management team has seen an improvement in communication and collaboration in coordinating care for enrollees after discharge. We have encountered facilities that are hard to engage (e.g., not responding to emails, not willing to meet or provide a time for a meeting). In regards telehealth, we continue to encounter enrollees that prefer in-person care. For those enrollees who engage with our telehealth partner, the process of referral from time of discharge, to outreach by our case manager and referral to telehealth Provider can be cumbersome and leads to gap closure after the 7-day. Our initiatives have been effective in increasing Screening, Brief Intervention, and Referral to Treatment (SBIRT) utilization; however, we continue to depend on Providers to identify enrollees with AOD abuse disorders given the limitation with sharing of AOD abuse diagnoses.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
e. Identify strategy for continued improvement or overcoming identified barriers: • We continue to monitor and improve Admission, Discharge, and Transfer (ADT) data we receive through internal sources and the Event Notification System (ENS) to ensure we have the most timely and accurate ED visits notifications that allows our care coordination teams to engage enrollees timely and have a higher chance to close gaps within seven days. We are leveraging other strategies such as implementation of incentives for BH outpatient Providers when closing FUM gaps in care. Our Clinical Transformation Managers (CTMs) work with our ACO (Accountable Care Organization) primary care practices by educating them about the FUM/FUA metrics, and SBIRT. Clinical Transformation Managers encourage ACO Providers to use ENS data to outreach enrollees after ED visits and perform the recommended follow-up visits.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure (both indicators).
Response
a. Describe why this weakness exists: • Primary Care Physicians (PCPs) were unaware of the timeframe enrollees needed to be seen for follow-up care when diagnosed with a substance use disorder. In addition, PCPs were unaware that they could schedule a follow-up appointment within their own practice and specialty within 14 days. Some PCPs were not aware that the follow-up did not have to be completed by a behavioral health Provider. Referral to Substance Use Disorder (SUD) treatment for more a more moderate to severe diagnosis outside of the PCP office is also a challenge for PCP's as they were not aware of SUD benefits and confidential case management available to enrollees with a SUD diagnosis.
b. Describe initiatives implemented based on recommendations: • United Healthcare FLORIDA conducted a root cause analysis on the Initiation of Alcohol or Other Drug Abuse or Dependence (AOD) Treatment and Engagement of AOD Treatment which noted a trend in PCPs diagnosing enrollees with a new AOD diagnosis. The Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence (IET) root cause analysis indicated that many PCPs are diagnosing enrollees with an AOD, but not ensuring SUD treatment is being initiated within 14 days of the diagnosis. Additional analysis resulted in the Plan identifying the top medical groups diagnosing enrollees with SUD in outpatient level of care year over year. United Healthcare FLORIDA met with the medical groups to discuss the IET metric, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and assist the groups in identification of barriers related to referral to treatment and billing for SBIRT. United Healthcare FLORIDA has been educating PCPs about SBIRT and providing resources around appropriate referrals to care. Additionally, a 3-Part On-Demand Series HEDIS® training has been provided to PCPs with a specific segment on SUD measures. PCPs have the opportunity to earn free Continuing Education Units (CEUs) to improve awareness of the need for enrollees to be referred to SUD treatment. Additionally, an interactive guide and Floridayer on SBIRT and Motivational Interviewing were developed, published on the United Healthcare Provider portal, and provided to PCP's and Obstetrician-Gynecologists (OBGYNs). The Floridayer shared with Providers incorporated multiple CEU

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
opportunities including the CEU developed by University of Floridaorida that was being promoted through Floridaorida Agency for Health Care Administration (AHCA). Claims codes for screening and the brief intervention were also provided to Providers encouraging them to screen and provide intervention if warranted while being paid for this service. A further analysis has been conducted month over month to determine if Providers are screening and providing the brief intervention and billing based on claims data.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • United Healthcare FLORIDA is continuing to monitor claims data for improvement and trends. The final rate for Initiation of Alcohol and Other Drug Dependence Treatment Initiation Total (IETI) in 2022 was 40.41%. As of November 3, 2023, the MY 2023 prospective rate is trending higher at 41.36%.
d. Identify any barriers to implementing initiatives: • Substance abuse confidentiality regulations are one barrier to timely follow-up care. Title 42 of the Code of Federal Regulations prevents the sharing of SUD diagnosis information without written consent. Obtaining written consent is challenging due to lack of accurate contact information on enrollees, enrollees not responding to outreach, and there is significant difficulty with Health Plan ability to obtain written consent in a timely manner to impact the short window of time on SUD treatment needed to improve the specific HEDIS® measure. Also, while many Providers are making referrals and setting up subsequent SUD treatment for enrollees, some enrollees lack motivation for treatment and may be in denial they have a substance use issue. Therefore, they are not following through with initiating treatment or remaining engaged in treatment. Additionally, one medical group we have not had success in meeting with, but we are working to meet with them to identify prescribing trends and technical specifications with the population of enrollees that have been identified through claims analysis.
e. Identify strategy for continued improvement or overcoming identified barriers: • United Healthcare is working with the care advocacy team to ensure use of the Iprompt portal to identify viable alternative phone numbers for enrollees so that they can be reached to assist in aftercare appointments. Educating PCPs about enrollees who may be discharging from an emergency room visit for SUD and need follow-up care or referral to other resources post discharge and exploring increasing peer support services further are other interventions taking place for continued improvement. United Healthcare is continuing to evaluate group practice performance, SBIRT billing, and educating in monthly meetings with PCPs. A presentation on SBIRT and IET highlighting data specific to Florida and best practices related to this metric is being promoted in a Provider Informational Expo held bi-annually.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support enrollees in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • In 2021 United and Optum engaged in a series of meetings with BH discharging facilities and outpatient Providers to investigate barriers around improving the HEDIS metric Follow- up after Hospitalization for

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Mental Illness (FUH). Outpatient Provider's feedback included late notification of discharge (no communication between outpatient facilities and discharging facilities), high chronicity population, homelessness (patient cannot be found after discharge), lack of transportation (Medicaid transportation takes too long and enrollees do not like to use it), enrollees with non-working cell phones (change cell phone numbers often), telehealth is available but many enrollees do not have access to smart phones/tablets/computers, most enrollees prefer in person visits, patients change addresses often, enrollees do not show up to appointments, do not know who is their assigned PCP (enrollee do not have insurance card with them) which is a barrier in connecting enrollees to medical services when needed. Inpatient Providers feedback: not enough outpatient facilities in some areas, limited 7-day appointments, only walk-in appointments (enrollees do not like walk-in appointments due to long waits). We also learned that some Providers were not aware of resources the health plan offers to Medicaid enrollees such as help with finding housing, or case management for enrollees with chronic conditions.
b. Describe initiatives implemented based on recommendations: • In 2021, we engaged inpatient and outpatient facilities who put enrollees in the FUH metric. During these meetings, we shared a list of enrollees who fell constantly in the FUH metric and had been established with their facility (based on claims data). We asked to follow up with the enrollee and to educate about the recommended follow-up visit promptly after a hospital inpatient event. Currently, we are reaching out to the discharging facilities with a different approach. Specifically, we are engaging with nine facilities that have admitted and discharged the most enrollees for inpatient level of care in 2021 and 2022. These facilities were targeted for strategic conversations and engagement based on the number of admissions, FUH 7-day rates, and a further potential impact analysis. The analysis is guiding intervention development around ways we can engage with these facilities and connect them with our internal Case Management departments, resources, and telehealth opportunities, if needed, when enrollees may not be established with a Provider or are unable to get into see their established Provider with 7 days of discharge.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We observed an improvement of 4.9% in FUH (7) from MY2021 (27.03%) to MY 2022 (28.36%). We did not observe an improvement in FUH (30). Improvement in the metric could be result of combined efforts implemented to improve FUH (Case Management, Virtual Case Health Workers, BH Provider Incentives, HEDIS metric Education Primary Care and Discharging Facilities, and Encounter Notification Service (ENS).
d. Identify any barriers to implementing initiatives: • We did not see an improvement in the FUH rate for the frequent admitters cohort identified in the initial facility outreach. We learned that these enrollees were hard to engage. The Providers and our Case Management team were familiar with these enrollees due to the frequency of inpatient events and lack of engagement in care. In our current initiative we have not completed the series of meetings.
e. Identify strategy for continued improvement or overcoming identified barriers: • Our Case Management team continues to leverage the relationships built with both inpatient and outpatient facilities for timely coordination of care, especially for enrollees with frequent inpatient admissions and high chronicity conditions. We are working to address some of the barriers mentioned by the Providers through various efforts: constant improvement and use of the ENS data (timeliness of notification), Housing Navigator Program (Homelessness), and telehealth network expansion (access to care). Our Plan has implemented various value-based programs and incentives that reward BH Providers that close gaps in care for the FUH metric.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for LTC Program
HSAG recommended the following: • Evaluate care coordination processes to determine whether there are opportunities to enhance the methods in which the plan engages with enrollees and facilities to support successful discharges to the community. For example, the plan should determine if it is effectively using all available data and information collected during an enrollee's initial facility admission, as well as upon hospital discharges to the facility, so that effective discharge planning occurs. Additionally, the plan should assess whether it has adequate community support in place to facilitate enrollees successfully transitioning to reside in a community setting within 100 days of admission to a facility.
Response
a. Describe why this weakness exists: • Public Health Emergency impacted enrollees' ability to isolate either in their home or Assisted Living Facility (ALF) thus increase the time in a Nursing Home (NH) setting. National work force challenges in 2022 impacted enrollees' ability to return home coupled with natural support decreased as individuals returned to work and no longer able to provide care in the home.
b. Describe initiatives implemented based on recommendations: • The plan utilizes resources such as Event Notification System (ENS) to track and monitor Home and Community Based Services (HCBS) enrollees that are hospitalized daily for timely and effective management of transitions of care. • Interdisciplinary team conducts weekly "HCBS At Risk Case Conferences" to discuss HCBS enrollees who are at risk for NH placement. • Provide robust Transition Allowance Benefit of up to $5,000 to assist and support enrollee in repatriation to the community. • Incentivize ALF Providers to accept placement of transitioning NH enrollees and HCBS enrollees at risk for NH placement. The additional payments (additional $200 a month) over 12 months motivates ALFs to keep enrollee in consistent community placement. • Implemented September 2022 Nursing Facility Repatriation and Diversion Program: Utilizes data from Impact Pro to stratify HCBS enrollees who show most at risk for NH placement within the following 12 months. Automated referrals to the Case Manager (CM) to act. Case Managers and Manager of Case Management (MCM) review impactable clinical triggers that stratify this enrollee as high risk and implement strategies to improve.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Since implementation, we have attained a goal of averaging greater than 90% of NH placements to be unavoidable from a previous 54% pre case conferences.
d. Identify any barriers to implementing initiatives: • The enrollee is able to retain a higher Personal Needs Allowance in a NH setting vs ALF. • Provider abrasion, in some cases the NH advocates to keep enrollees in their facility.
e. Identify strategy for continued improvement or overcoming identified barriers: • We have integrated other initiatives to support the enrollee to remain in the community such as Careforth for caregiver supports and CareBridge for 24/7 clinical support. In 2024 We are looking to partner with Community Based Organizations to provide additional case management support.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Assessment
HSAG recommended the following: • United-C was unable to sustain the statistically significant improvement in the performance indicator rates achieved during Remeasurement 1 for the Administration of the Transportation Benefit PIP. For unsuccessful interventions, the plan should make data-driven decisions to revise the current intervention or discontinue it and implement new interventions. • The plans should consider using QI science tools such as process mapping, FMEA, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small-scale using PDSA cycles should be ramped up and adopted planwide in order to impact the entire eligible population.
Response
a. Describe why this weakness exists: • In 2020, UHCCP Florida transitioned to a new transportation vendor which provided a new baseline on the Administration of the Transportation Benefit metric. Calendar year 2020 included performance data for both vendors (half of the year covered by original vendor, and the other half by the new vendor). The new vendor had a lower percentage of Leg A Trips arriving on Time to Scheduled Appointment (on time performance or OTP).
b. Describe initiatives implemented based on recommendations: • The Quality Team worked collaboratively with the Operations Team, and the new vendor Modivcare, in identifying barriers and opportunities to improve the OTP metric. Our team used the Prioritization Worksheet for Performance Improvement Projects (QAPI tool) to help prioritize barriers. The highest priority ranking barriers was “underperforming transportation Providers (TPs) in meeting pick up and drop off times.” Modivcare implemented various interventions that specifically target this priority barrier. Interventions included identifying underperforming TPs and placing them in a Performance Improvement Plan (PIP) and/or Corrective Action Plan (CAP), and the Champions program. The Champions program implementation followed a similar methodology to that of a PDSA. Modivcare assessed the initiative and later the program was integrated as a part of their regular operations. The Champions Program rewarded TPs who performed above expectations with more standing orders. In 2021, the vendor identified that most of the low OTP were due to trips for facilities with standing orders for dialysis. The Champions program began to target these types of facilities. The vendor created a Very Important Person (VIP) enrollee list, matching facilities with 1-2 TPs. In addition to improving OTP goals, vendor worked towards improving enrollee experience, enhance communication between facilities and TPs and reduced complaints. Modivcare continuously collects enrollee feedback after an enrollee is assisted with a ride or when they make a reservation. The Post Trip Surveys are offered via phone call within 24 hours of a completed ride. Survey results are reviewed regularly by the corresponding business units (Contact Center for Post Call, and Network for Post Trip). For unfavorable Post Call results, agents are coached to improve their soft skills. For unfavorable Post Trip Survey, the local network team reviews which specific transportation Providers are yielding unacceptable survey responses and implements actions to correct the behavior. The initial attempt may include a conversation with the TP to review the results and identify the specific driver's behavior. Repetitive results may yield a reduction in rides assigned to the TP until survey results improve.

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • From CY 202 (86.43%) to CY 2021 (87.%) we observed an improvement in OTP of 1.6%. From CY 2020 to CY 2022 (89.90%) we observed a 4.0% improvement. In 2023, the Modivcare has sustained performance over the 90% target for 8 months in a row.
d. Identify any barriers to implementing initiatives: • Implementing the Champions program was difficult with Substance Abuse facilities due to HIPPA regulations that limit the sharing of information for patients/enrollees with sensitive conditions such as substance use disorders.
e. Identify strategy for continued improvement or overcoming identified barriers • The Champion's program was fully integrated into the vendor's regular operations processes due to its positive impact on the OTP and other transportation metrics. The vendor in collaboration with the health plan continued to work on identifying other opportunities for improvement. In 2023, the vendor began utilizing Google Drive Time. This software works in the back end with reservation and tracking systems to support a more efficient network. This is only available for providers that use this technology and helps to monitor on time performance.
HSAG Assessment

Specialty Plans

Children's Medical Services-S

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendation for Access/Availability of Care

HSAG recommended the following:

- Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.

Response

a. Describe why this weakness exists:
- The PHE resulted in members avoiding the use of preventive and ambulatory services due to the fear of exposure.

b. Describe initiatives implemented based on recommendations:
- CMS Health Plan is promoting member utilization of a 24/7 telemedicine program through the Teladoc health app. Members will be mailed a flyer promoting Teladoc use once the flyer has received AHCA/DOH approval.
- The Concierge Team calls members with care gaps and helps them schedule appointments. The Concierge Team is an outbound call team dedicated to addressing gaps in care as identified by NCQA. The primary focus for pediatric calls is to schedule the children with the PCP for annual well visits and immunizations.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- None Identified.

d. Identify any barriers to implementing initiatives:
- Some members may not have access to smart phones or devices.
- Bad addresses due to frequent residence changes.
- Member no-show rates are high after appointments are made.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Case Management assists with scheduling medical appointments, as appropriate.
- MyHealthDirect is utilized to enhance efforts to schedule preventive health appointments.
- CMS Health plan continues work to expand network access to Urgent Care and Minute Clinics.

HSAG Assessment

Recommendation for Pediatric Care Domain

HSAG recommended the following:

- Identify best practices for ensuring children receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of MD offices due to the fear of exposure.
b. Describe initiatives implemented based on recommendations: • Immunization Tool Kit - Small practices with decent member volumes but poor vaccine compliance rates were targeted to receive the Immunization Tool kit in 2022. The Quality Practice Advisor (QPA) team met with these practices and assisted with identifying a vaccine champion in the office, posting vaccine policies, and preparing a vaccine tool kit (this kit included resources from the CDC, Pfizer, Merck, and the American Cancer Society). The office was also assisted to create an alert system for vaccines that were due and the QPA met monthly with the vaccine champion to ensure measures were implemented. • Shoes for Shots (aka Healthy Steps Program) – Partnered with Community Medical Group (CMG) to provide free shoes and backpacks to kids who came and received vaccines. CMG advertised the event via email, radio, posters, social media, and tv ads.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Of the 22 practices that were targeted for the Immunization Toolkit: 20 practices improved CIS Combo 3, 17 practices improved for CIS Combo 10, 19 practices improved for IMA Combo 1, and 19 practices improved for IMA Combo 2 • Shoes of Shots: Almost 200 members received vaccines.
d. Identify any barriers to implementing initiatives: • Immunization Tool Kits: 2 practices lacked baseline data to determine change. • Shoes for Shots: Since members did not have to RSVP, the shoe size had to be obtained, and members had to return a week later to pick up the shoe order.
e. Identify strategy for continued improvement or overcoming identified barriers: • If Shoes for Shots is continued, additional organizational partnerships will be explored.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to identify barriers to children receiving well-child visits. Upon identification of any root causes contributing to these gaps in care, implement appropriate interventions to improve the use of evidence-based practices related specifically to *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits.*
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of MD offices due to the fear of exposure.
b. Describe initiatives implemented based on recommendations: • The Concierge Team calls members with care gaps and helps them schedule appointments. • Members receive MyHealthPays reward of $10 for completing an Annual Well Child Visit, ages 0-30 months.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS W30-6+ rate increased from 33.25% for CY 2021 to 37.70% for CY 2022.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why women are not receiving chlamydia screenings. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving chlamydia screenings.
Response
a. Describe why this weakness exists: • Providers not aware of need to conduct urine screening in members not yet receiving pap smears. • Providers not aware of need to conduct urine screening in members not yet sexually active. • Members decline screening due to fear of parents discovering they are sexually active.
b. Describe initiatives implemented based on recommendations: • The Concierge Team calls members with care gaps and helps them schedule appointments. • Utilization of OB Care Gap Report to conduct targeted member and provider education. • Quality Practice Advisors conduct virtual and in-person Provider visits to improve rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS CHL measure increased from 47.55% for CY 2021 to 49.80% for CY 2022.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. Analyze data and consider whether there are disparities within the plan's populations that contributed to lower access to care. Upon identification of a root cause, implement appropriate interventions to improve quality of, access to, and timeliness of prenatal and postpartum care.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Response
a. Describe why this weakness exists: • Providers are incorrectly coding positive pregnancy tests. • Members aren't aware of pregnancy or hide pregnancy from parent/guardian until late in prenatal care. • Members are not returning for postpartum care because they do not understand the importance.
b. Describe initiatives implemented based on recommendations: • OB/GYN Incentive Program to incentivize OB/ GYNs for each care gap they close. ($50 per closed care gap for Prenatal Visits and Postpartum Visits.) • Utilization of OB Care Gap Report to conduct targeted member and provider education • Quality Practice Advisors conduct virtual and in-person Provider visits to improve rates
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS PPC-Pst measure rate increased from 61.74% for CY 2021 to 69.50% for CY 2022. • The HEDIS PPC-Pre measure rate increased from 62.61% for CY 2021 to 63.12% for CY 2022.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members are not adequately controlling their blood pressure. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to controlling high blood pressure.
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of MD offices due to the fear of exposure. • 18-21 year old age group does not understand/appreciate the importance of controlling high blood pressure.
b. Describe initiatives implemented based on recommendations: • Develop text message campaign to seek feedback on root causes from members who are not in the CPB numerator. Members will receive a text message with a link to an online survey that will allow for member feedback. Due to the timing required for development, AHCA/ DOH approval, and system implementation, we are aiming for text distribution in Q3 of 2024.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • To be determined once intervention is implemented.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG Assessment • NA, no results available at time of reporting.
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance for the *Comprehensive Diabetes Care* measure.
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of MD offices due to the fear of exposure. • 18-21 year old age group does not understand/appreciate the importance of controlling high blood pressure. • Endocrinologists did not have visibility into the care gaps of the members they were seeing.
b. Describe initiatives implemented based on recommendations: • Endocrinology Incentive Program initiated in March 2023 to incentivize providers for closing care gaps. ($75 for each Blood Pressure Control for Patients with Diabetes closed care gap, $50 for each Eye Exam for Patients with Diabetes closed care gap, and $50 for each Hemoglobin A1c Control for Patients with Diabetes closed care gap.) • Utilization of Care Gap Report to conduct targeted member and provider education. • Quality Practice Advisors conduct virtual and in-person Provider visits to improve rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • None.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment • NA, no results available at time of reporting.
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why members who access the ED for AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.
Response
a. Describe why this weakness exists: • Follow-up visits are not scheduled before member leaves ED. • Member refusal.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Not a perceived problem by member family. • Member readmission.
b. Describe initiatives implemented based on recommendations: • Care Management follow-up with member after ED visits for AOD abuse or dependence to help schedule follow-up care. • BH provider care gap reports are utilized by Quality Practice Advisors to identify and meet with providers with Behavioral Health HEDIS open care gaps. Providers are then educated on resolving behavioral health deficiencies which includes improving timely follow-up after ED visits for AOD.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS FUA measure increased from 3.45% for CY 2021 to 19.74% for CY 2022 which exceeded the goal of 13.39% for CY 2022.
d. Identify any barriers to implementing initiatives: • None.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* measure.
Response
a. Describe why this weakness exists: • Member refusal. • Not a perceived problem by member family. • Stigma of mental health care.
b. Describe initiatives implemented based on recommendations: • Behavioral Health Incentive Program initiated in March 2023 to incentivize providers for closing care gaps.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • Provider incorrect coding.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continued provider education by Quality Practice Advisors.
HSAG Assessment • NA, no results available at time of reporting.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • Follow-up visits are not scheduled before member leaves inpatient facility. • Member refusal. • Not a perceived problem by member family. • Member readmission.
b. Describe initiatives implemented based on recommendations: • Care Management follow-up with member after hospitalization for mental illness to help schedule follow-up care. A daily discharge report is utilized to identify members who are being discharged after Behavioral Health admissions. The primary assigned Care Manager is responsible to outreach member within 2 business days of notification of hospital discharge. The Care Manager conducts an assessment and offers to assist member to schedule appointment for Behavioral Health follow-up care.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS FUH measure increased from 30.33% for CY 2021 to 40.95% for CY 2022 which exceeded the goal of 37.99% for CY 2022.
d. Identify any barriers to implementing initiatives: • Members contact information is sometimes not correct.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue current processes.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Assessment
HSAG recommended the following: • For SFY 2021–2022, Children's Medical Services-S reported finalized Remeasurement 1 (CY 2020) results for the Youth Transitions to Adult Care and Reducing Asthma Related PPEs for Pediatric Enrollees PIPs. For the Youth Transitions to Adult Care PIP, Children's Medical Services-S reported an increase in the performance indicator rate; however, the increase was not statistically significant over the baseline. The plan did not report any evidence of significant clinical or programmatic improvement. HSAG recommends that the plan make data-driven decisions to revise the current intervention or discontinue it and implement new interventions. • The plans should consider using QI science tools such as process mapping, FMEA, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plans should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small scale using PDSA cycles should be ramped up and adopted planwide in order to impact the entire eligible population.
Response
a. Describe why this weakness exists: • CMS members have complex medical conditions and prefer to stay with pediatric providers as long as possible. • Pediatric providers do not require members to change to an adult provider once they turn 18 years old.
b. Describe initiatives implemented based on recommendations: • Discontinued "Transition Age Youth Workgroup" intervention based on agency recommendations. • Discontinued "Educate members regarding how to search for adult providers" intervention based on agency recommendation. • Create survey to obtain member/guardian feedback concerning barriers to transitioning to adult providers.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
• NA, no results available at time of reporting.

Clear Health-S

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • There are various challenges as it related to improving member utilization of preventive and ambulatory services. The Plan is working on expanding network access, educating members on the importance of preventive care, and collaborating closely with Providers. • Human Immunodeficiency Virus (HIV) related clinical and long-term care management challenges such as chronic inflammation and neurological complications can affect thinking and behavior. It can complicate existing mental health conditions and hinders engagement in care. • In addition to the multiple social, emotional, and clinical challenges, people living with HIV are often stigmatized. The acceptance and internalization of societal negative attitudes and beliefs about HIV, can lead to reluctance in accessing healthcare services.
b. Describe initiatives implemented based on recommendations: • To address Adults' Access to Preventive/Ambulatory Health Services (AAP), Clear Health Alliance (CHA) has implemented multiple initiatives including: − Provider Level o Collaborating with providers on targeted clinic sessions o Hold monthly collaborative meetings with priority groups to share and review data. o Conduct a workgroup with our PR partners to review data and identify members with the largest non-compliance in their panel to explore barriers. o CHA regularly identifies and engages the top providers that have the largest number of AAP care gaps monthly. ▪ CHA provides those groups with rates and member care gap lists as needed. ▪ Enhanced to distinguish new vs established patients. − Provider Education on Telehealth is ongoing. o Covers all approved modalities. ▪ Live Video ▪ Store and Forward ▪ Remote Patient Monitoring − Patient-Centered Medical Home (PCMH) Incentive Program o The Plan increased provider education towards appointment access and availability standards and requirements. o The Plan is conducting live and on-demand trainings to provider office staff and appointment schedulers to increase awareness and education towards appointment availability and alternate methods of access to care such as Telehealth, other providers, and alternate locations, expanding member awareness on access to care options when their provider is unavailable.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
o The Plan conducts analysis of the quarterly appointment wait times report to identify non-compliance trends, outliers by provider type. o Provider outreach to address access to care limitations and non-compliance reported in the Wait times report. • System-Level − Using a new supplemental database, the Plan has improved the completeness and accuracy of claims/encounters received from urgent care facilities. • Member-Level − Engage members to assist with attending targeted clinic sessions. − Conduct outreach to members with open care gaps. − Facilitate member education regarding services available to engage with their PCP and promote completion of preventive screenings. − Assist members in scheduling appointments and eliminate barriers to attending appointments. − To educate and encourage members to use Telehealth, CHA has implemented the following initiatives: o Live Health Online – ability for members to video chat with PCPs and Urgent Care doctors 24/7 o Behavioral Health – ability for members to video chat with Behavioral Health providers 24/7 − Ongoing text campaigns tailored for AAP. − All CHA members are assigned a case manager upon enrollment to provide support and assistance closing healthcare gaps. − The Plan also incorporated dedicated workgroups focused on access to care issues and member complaints.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Year over Year improvement seen in Appointment Wait Times. • Year over Year Improvement in the Plan's Access and Availability rates. • Enhanced communication between the Plan and its Provider network with regards to member-related and access to care issues.
d. Identify any barriers to implementing initiatives: • Staff turnover in provider offices affecting education and awareness towards Healthcare Effectiveness Data and Information Set (HEDIS) measures. • Provider schedules are often overbooked, impacting the availability for members to schedule appointments when needed. • Transportation-related barriers. • Continuing to monitor the accuracy of our provider network/directory, supported using secret-shopper activities. • Engagement barriers affecting people living with HIV such as emotional and health related stress, homelessness, low-literacy skills, poverty, and stigma.
e. Identify strategy for continued improvement or overcoming identified barriers: • Monthly deep dives into provider panels are conducted. • Continue to track all AAP initiatives monthly with key stakeholders to review and analyze intervention and outcome data to monitor improvement progress. • The Plan has reinstated and has increased the frequency of its Enrollee Advisory Committees (EAC) to better incorporate enrollee feedback.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

- Continue to work with and educate our provider network.
- Continue current efforts towards improving appointment availability and stressing the importance internally and among the provider networks.

HSAG Assessment

Recommendation for Pediatric Care Domain

HSAG recommended the following:

- Identify best practices for ensuring children receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.

Response

a. Describe why this weakness exists:

- Among the various challenges to improve rate of adolescence who receive medically appropriate vaccinations include overall lack of commitment and/or hesitancy. The Plan continues to work on providing members and providers education on the importance of preventive care, including appropriate vaccinations.
- Common key factors affecting adolescents with HIV disproportionately include unstable housing, high prevalence of behavioral and mood disorders, transportation barriers and limited familial or social support. Other unique cognitive and physical developmental factors such as risk-taking behaviors, neurocognitive impairment and mental health comorbidities negatively impact compliance with appropriate preventive vaccinations.

b. Describe initiatives implemented based on recommendations:

- Member Focused Efforts:
  - Healthy Behaviors Member Incentive – Human Papillomavirus (HPV) Series completion
  - All CHA members are assigned a case manager upon enrollment to provide support and assistance closing healthcare gaps.
  - Direct-to-Member Outreach
  - Text campaigns, Interactive Voice Response (IVR), email, social media.
  - Back to School Readiness events.
  - Flu Season and Immunization Drive-Ups.
  - Appointment scheduling assistance with Primary Care Provider (PCP).
  - Promoting education and access to incentives as part of the Benefits page and Patients portal.
  - Time to Act - CHA care coordinators block time weekly to work exclusively with children and adolescents to close gaps in care.
  - Clinic Sessions
  - Targeted outreach encouraging all recommended vaccinations.
  - Clinic session attendees incentivized for attendance/closing care gap during session.
  - Provider Education and Collaboration

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
– Educating providers on newly recommended age guidelines for immunizations such as HPV. – Provider Bulletins – Updated annually per guidance on coding & reimbursement rates. – Distributed to PCPs and Specialists via fax. – Email & Provider website postings completed. – Data Sharing – The Plan sends providers lists of members in their panel who are due for a vaccination within 120 days. – Cobranding opportunities to their patients for education about schedule of preventive visit and immunizations. – Pharmacy Communications. – Clinic Session Collaboration – Worked with Providers to host specific clinic days for pediatric vaccinations. – Provider Flu Trainings conducted. – Continuing Medical Education (CME) credits are offered to participants.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Year Over Year improvement seen in the Plan's Human papillomavirus (HPV) rates.
d. Identify any barriers to implementing initiatives: • Increased hesitancy towards immunizations. • Adolescent refusal/lack of commitment to go to the doctor. • Psychosocial stressors including comorbid cognitive or mental health issues, poverty, homelessness, or illicit drug use. • HIV related stigma in adolescence has a negative impact on access and engagement in care. • PHE Impact: – It is difficult to ascertain the impact of PHE on these rates. The overall impact of the pandemic, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from further improving its rates of immunizations/vaccines.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Plan has seen encouraging results from these efforts and will continue to meet with key stakeholders monthly to review the progress and effectiveness of each intervention. • Continue member and provider education efforts. • All CHA members are assigned a case manager upon enrollment to provide support including vaccination education and assistance closing healthcare gaps. • CHA weekly interdepartmental collaborative meetings to monitor outreach efforts, and address challenges.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to identify barriers to children and adolescents receiving well-care visits. Upon identification of any root causes contributing to these gaps in care, implement appropriate interventions to improve the use of evidence-based practices related specifically to the *Child and Adolescent Well-Care Visits—Total* measure indicator.
Response
a. Describe why this weakness exists: • Among the various challenges to improve rate of adolescence who receive medically appropriate well care visits include overall lack of commitment and/or hesitancy. The Plan continues to work on providing members and providers education on the importance of preventive care, including appropriate. • Common key factors affecting adolescents with HIV disproportionately include unstable housing, high prevalence of behavioral and mood disorders, transportation barriers and limited familial or social support. • Other unique cognitive and physical developmental factors such as risk-taking behaviors, neurocognitive impairment, and mental health comorbidities, negatively impact compliance with appropriate Well-Care Visits. • Individuals living with HIV face multiple social, emotional, and clinical challenges and are often stigmatized. The acceptance and internalization of societal negative attitudes and beliefs about HIV, can lead to reluctance in accessing healthcare services, hindering engagement in care.
b. Describe initiatives implemented based on recommendations: • Member Focused Efforts: − Healthy Behaviors Member Incentive – Well Child Care − All CHA members are assigned a case manager upon enrollment to provide support including education on the importance of Well- Child Care visits and assistance closing healthcare gaps. − Direct-to-Member Outreach o Text campaigns, Interactive Voice Response (IVR), email, social media o Back to School Readiness events o Appointment scheduling assistance with PCP o Promoting education and access to incentives as part of the Benefits page and Patients portal o Time to Act – CHA case managers block time weekly to work exclusively with children and adolescents to coordinate services. − Clinic Sessions o Targeted outreach encouraging all recommended age-appropriate screenings. o Clinic session attendees incentivized for attendance/closing care gap during session. − Provider Education and Collaboration o Educating providers on recommended guidelines and periodicity schedule o Provider Bulletins o Updated annually per guidance on coding & reimbursement rates. o Distributed to PCPs and Specialists via fax.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
o Email & Provider website postings completed. o Data Sharing o The Plan sends providers lists of members in their panel who are due for a well child visit. – Cobranding opportunities to their patients for education about schedule of preventive visits – Pharmacy Communications – Clinic Session Collaboration o Worked with Providers to host specific clinic days for pediatric well child visits. – CMEs are offered to participants
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Plan has expanded on its current strategies via the initiatives listed above and expects to see improvement as a result of these efforts.
d. Identify any barriers to implementing initiatives: • Adolescent refusal/lack of commitment to go to the doctor. • Unable to contact members due to incorrect information. • PHE Impact: – It is difficult to ascertain the impact of the PHE on these rates. The overall impact of the pandemic, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from further improving its rates of immunizations/vaccines. • Engagement barriers affecting people living with HIV such as emotional and health related stress, low-literacy skills, poverty, and stigma.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Plan has seen encouraging results from these efforts and will continue to meet with key stakeholders monthly to review the progress and effectiveness of each intervention. • Continue member and provider education efforts. • All CHA members are assigned a case manager upon enrollment to provide support including vaccination education and assistance closing healthcare gaps. • CHA weekly interdepartmental collaborative meetings to monitor outreach efforts, and address challenges.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to identify barriers to children receiving lead screenings. Upon identification of any root causes contributing to these gaps in care, implement appropriate interventions to improve the use of evidence-based practices related specifically to the *Lead Screening in Children* measure.
Response
a. Describe why this weakness exists: • Among the various challenges to improve rate of adolescence who receive lead screening include overall lack of commitment and/or hesitancy.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• The Plan continues to work on providing members and providers education on the importance of preventive care, including appropriate vaccinations. • Individuals living with HIV face multiple social, emotional, and clinical challenges and are often stigmatized. The acceptance and internalization of societal negative attitudes and beliefs about HIV, can lead to reluctance in accessing healthcare services, hindering engagement in care. In addition, people living with HIV have a complex care process and are subject to long term management.
b. Describe initiatives implemented based on recommendations: • Member Focused Efforts: − Healthy Behaviors Member Incentive – Well Child Visits − All CHA members are assigned a case manager upon enrollment to assist with coordination of services. − Direct-to-Member Outreach o Text campaigns, Interactive Voice Response (IVR), email, social media o Back to School Readiness events o Appointment scheduling assistance with PCP o Promoting education and access to incentives as part of the Benefits page and Patients portal o Time to Act – CHA case managers log time weekly to work exclusively with children and adolescence to coordinate services. − Clinic Sessions o Targeted outreach encouraging all recommended age-appropriate screenings. o Clinic session attendees incentivized for attendance/closing care gap during session. − Provider Education and Collaboration o Educating providers on recommended guidelines and periodicity schedule o Provider Bulletins ▪ Updated annually per guidance on coding & reimbursement rates. ▪ Distributed to PCPs and Specialists via fax. ▪ Email & Provider website postings completed. − Data Sharing − The Plan sends providers lists of members in their panel who are due for a well child visit. o Cobranding opportunities to their patients for education about schedule of preventive visits o Pharmacy Communications o Clinic Session Collaboration − Worked with Providers to host specific clinic days for pediatric well child visits. o CMEs are offered to participants.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Plan observed significant improvement on compliance with Lead Screening year over year in children.
d. Identify any barriers to implementing initiatives: • Adolescent refusal/lack of commitment to go to the doctor. • Unable to contact members due to incorrect information. • PHE Impact:

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
− It is difficult to ascertain the impact of the PHE on these rates. The overall impact of the pandemic, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from further improving its rates of immunizations/vaccines. • Psychosocial stressors including comorbid cognitive or mental health conditions, poverty, homelessness, or illicit drug use. • HIV related stigma in health has a negative impact on access and engagement in care.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Plan has seen encouraging results from these efforts and will continue to meet with key stakeholders monthly to review the progress and effectiveness of each intervention. • Continue member and provider education efforts. • All CHA members are assigned a case manager upon enrollment to assist with vaccination education. • CHA weekly interdepartmental collaborative meetings to monitor outreach efforts, and address challenges.
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why women are not receiving chlamydia screenings. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving chlamydia screenings.
Response
a. Describe why this weakness exists: • There are various challenges as it related to improving member utilization of preventive and ambulatory services. • The Plan is working on expanding network access, educating members on the importance of preventive care, and collaborating closely with Providers. • Individuals living with HIV face multiple social, emotional, and clinical challenges and are often stigmatized. The acceptance and internalization of societal negative attitudes and beliefs about HIV, can lead to reluctance in accessing healthcare services, hindering engagement in care. • People living with HIV have a complex care process and are subject to long term management.
b. Describe initiatives implemented based on recommendations: • Provider Level − Collaborating with providers on targeted clinic sessions − Hold monthly collaborative meetings with priority groups to share and review data. − Conduct a workgroup with our public relations (PR) partners to review data and identify members with the largest non-compliance in their panel to explore barriers. − CHA regularly identifies and engages the top providers that have the largest number of care gaps monthly. o CHA shares rates and member care gap lists and includes case manager contact information to facilitate collaboration.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
o Enhanced to distinguish new vs established patients. − Provider Education on Telehealth is ongoing. o Covers all approved modalities. ▪ Live Video ▪ Store and Forward ▪ Remote Patient Monitoring − Patient-Centered Medical Home (PCMH) Incentive Program − The Plan increased provider education towards appointment access and availability standards and requirements − The Plan is conducting live and on-demand trainings to provider office staff and appointment schedulers to increase awareness and education towards appointment availability and alternate methods of access to care such as Telehealth, other providers, and alternate locations, expanding member awareness on access to care options when their provider is unavailable. − The Plan conducts analysis of the quarterly appointment wait times report to identify non-compliance trends, outliers by provider type. − Provider outreach to address access to care limitations and non-compliance reported in the Wait times report. • System-Level − Using a new supplemental database (approved by a HEDIS-auditor), the Plan has improved the completeness and accuracy of claims/encounters received from urgent care facilities. • Member-Level − Engage members to assist with attending targeted clinic sessions. − Conduct outreach to members with open care gaps − Facilitate member education regarding services available to engage with their PCP and promote completion of preventive screenings. − Assist members in scheduling appointments and eliminate barriers to attending appointments. − To educate and encourage members to use Telehealth, CHA has implemented the following initiatives: o Live Health Online – ability for members to video chat with PCPs and Urgent Care doctors 24/7 o Behavioral Health (BH) – ability for members to video chat with Behavioral Health providers 24/7 − All CHA members are assigned a case manager upon enrollment to assist with care gaps. − The Plan also incorporated dedicated workgroups focused on access to care issues and member complaints.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Plan observed a significant improvement year over year and met the benchmark in 2022.
d. Identify any barriers to implementing initiatives: • Staff turnover in provider offices affecting education and awareness towards HEDIS measures. • Provider schedules are often overbooked, impacting the availability for members to schedule appointments when needed. • Transportation-related barriers • Many people living with HIV struggle with stigma and exclusion, aggravated by stressors including comorbid cognitive or mental health issues, poverty, homelessness, or illicit drug use.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
e. Identify strategy for continued improvement or overcoming identified barriers: • The Plan has reinstated and has increased the frequency of its Enrollee Advisory Committees with a focus on Women's care to address specific female issues. • Continue to work with and educate our provider network. • Continue current efforts towards improving appointment availability and stressing the importance internally and among the provider networks. • CHA collaborative and interdepartmental weekly care meetings to track outreach efforts, identify challenges and opportunities.
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. Analyze data and consider whether there are disparities within the plan's populations that contributed to lower access to care. Upon identification of a root cause, implement appropriate interventions to improve quality of, access to, and timeliness of prenatal and postpartum care.
Response
a. Describe why this weakness exists: • There are various challenges as it related to improving member utilization of preventive and ambulatory services. The Plan is working on expanding network access, educating members on the importance of preventive care, and collaborating closely with Providers. • Prenatal depression, anxiety and stress disorders are prominent in pregnant women living with HIV. Clinical and long-term care management challenges such as chronic inflammation and neurological complications can affect individuals thinking, behavior, and complicate existing mental health conditions negatively impacting timeliness of prenatal and postpartum care. • HIV-related stigma among pregnant women has been a significant predictor of low social support. The acceptance and internalization of societal negative attitudes and beliefs about HIV, can lead to reluctance in accessing healthcare services.

b. Describe initiatives implemented based on recommendations:
• Encounter Notification System (ENS) alerts developed to identify all pregnant women.
  − The Plan conducts outreach to all members identified in the ENS report to promote Doula services, provide education, and assist with scheduling a prenatal appointment.
  − The Plan will continue to address and mitigate any barriers linked to this intervention as part of its ongoing evaluation determine the impact of this initiative.
• OB Quality Incentive Program (OBQIP)
• Promote utilization of Medication Assisted Treatment (MAT) and BH services.
• Promote the use of Doula services through a partnership with a National Doula provider.
• Gestational Diabetes Program for High-Risk Members
• Early Identification of pregnant women
• Member education materials developed.
• Provider Bulletins developed to address prenatal and postpartum benefits.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

• Healthy Rewards for Maternity
• Enrollee Advisory Committees targeting pregnant enrollees.
• Promotion and use of the 'My Birth Matters' materials sent monthly to pregnant members.
• Working with the Agency on implementing a universal Pregnancy Notification Form.
• Ongoing text campaigns targeting Prenatal and Postpartum visit compliance.
• All CHA pregnant women have two case managers, one for HIV and one for OB specifically. OB becomes the primary case manager during pregnancy until 84 days after delivery.
• The Plan is working with a new community-based partner in hosting baby showers that connect members with resources in their community.
• **Taking Care of Baby and Me program:**
  − My Advocate - components include HRA, educational info, reminder calls, and potential incentives. The program strives to improve birth outcomes by:
    o Promoting preconception care
    o Promoting prenatal care
    o Increasing the number of prenatal care visits
    o Reducing infant mortality
    o Reducing premature births
    o Reducing incidence of low birth weight
    o Reducing Neonatal Intensive Care Unit (NICU) admissions and lengths of stay
    o Improving identification of and access to treatment for perinatal depression
    o Promoting education and access to treatment for smoking cessation and substance use disorders
    o Improving access to and completion of postpartum care visits
    o The program centers on achieving the earliest possible identification of and communication with a new or existing pregnant member, completing an assessment of the member's risk, and developing and enacting a collaborative plan of care for mother and her newborn. In general, the program also endeavors to increase the awareness of and advocates for the reproductive health of all members and the importance of well child Early Periodic Screening and Diagnostic Testing (EPSTD). This includes:
    o Conducting problem-based comprehensive care planning that includes measurable goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments.
    o Coordinating care with PCPs, specialty providers, ancillary providers, and community resources
    o Educating members on healthcare for themselves and their infants
    o The Maternal Child Services model delivers a seamless, coordinated approach, offers a seamless, coordinated approach. From identification through care planning, trained staff seeks to improve the overall quality of life, functional status, and health outcomes for pregnant members and their newborns.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For Plan Do Study Act (PDSA) Performance Improvement Process (PIP) participants there has been an increase in the rate of prenatal screenings among pregnant members with prior Behavioral Health (BH)/Substance Use Disorder (SUD)

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Majority of provider groups participating in the OBQIP program show an improvement in C-section rates and Preterm Birth rates. • The Gestational diabetes program has resulted in fewer Neonatal Intensive Care Unit (NICU) babies and improved health outcomes for Moms.
d. Identify any barriers to implementing initiatives: • Increase in the denominators has impacted the eligible population. • New enrollees with a lack of prenatal compliance makes it difficult to identify and track some pregnant members. • For members with prior BH/SUD issues there is a potential gap in care among the OB/Provider, the Plan, and a BH specialist.
e. Identify strategy for continued improvement or overcoming identified barriers: • The Plan has reinstated and has increased the frequency of its Enrollee Advisory Committees with a focus on Women's care to address specific female issues. • Continue to work with and educate our provider network. • Continue current efforts towards improving appointment availability and stressing the importance internally and among the provider networks. • CHA collaborative and interdepartmental weekly care meetings to track outreach efforts, identify challenges and opportunities. • All CHA pregnant women have two case managers, one for HIV and one for OB specifically. OB becomes the primary case manager during pregnancy until 84 days after delivery.
HSAG Assessment
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members are not adequately controlling their blood pressure. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to controlling high blood pressure.
Response
a. Describe why this weakness exists: • People with HIV are more likely to have high blood pressure, in part because of treatments and repercussions of the condition itself, such as vascular inflammation, intestinal problems, high cholesterol, HIV-related kidney disease and other conditions. Antiretroviral medications can also trigger conditions that lead to inflammation, and it is one of the underlying factors contributing to the development of hypertension. • Unstable housing, transportation barriers, and other comorbidities are prevalent in people living with HIV and has a negative impact in treatment adherence
b. Describe initiatives implemented based on recommendations: • Collaborate with members who have high blood pressure and have a history of treatment non-compliance and develop short-term and long-term goals. • Verbal and/or written education provided to each member.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Assistance with Durable Medical Equipment, Medical & BH appointments. • Coordination of home health services. • Send members blood pressure kits which include monitor to check daily. • Monthly text campaigns for the High Blood Pressure population • Clinic days to assist providers with scheduling members for their recommended appointments. • Monthly circulation of the gaps in care report to the Case Managers in order to target their assigned members. • All CHA members are assigned a case manager upon enrollment to assist with care gaps. • Provider Education on the importance of recommended screening.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Plan has seen a slight improvement in high blood pressure screenings and continues monitoring and analyzing outcome data monthly.
d. Identify any barriers to implementing initiatives: • Many enrollees have multiple comorbidities which makes it challenging when attempting to prioritize a sub-set of this population. As such, CHA enhanced its methods to better stratify and prioritize enrollees based on the acuity and value of their identified gaps in care. • Chronic HIV related inflammation, unwanted side effects and medicine interactions makes high blood pressure treatment challenging in people living with HIV.
e. Identify strategy for continued improvement or overcoming identified barriers: • Increase frequency of tracking outcome data from monthly to weekly basis and meet regularly with key stakeholders to review and analyze intervention and outcome data in order to determine improvement progress. CHA will also continue to obtain enrollee feedback to better understand the barriers and impact from an enrollee perspective. • CHA will also continue to obtain enrollee feedback to better understand the barriers and impact from an enrollee perspective. • Continue to hire and obtain appropriate resources as needed. • Dedicated clinic days targeting CHA gap needs.
HSAG Assessment
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance for the *Comprehensive Diabetes Care* measure.
Response
a. Describe why this weakness exists: • Prevalence of diabetes among HIV-infected adults is higher compared with the general population. • HIV related inflammation, unwanted effects of some HIV medications as well as the interaction of some medicines for lowering blood sugar with HIV treatment, present significant challenges in managing diabetes in people living with HIV. • People with HIV might not respond to diabetes treatment in the same way that people without HIV do.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Unstable housing, food insecurity, transportation barriers, high prevalence of other comorbidities, and limited familial or social support are key factors that disproportionately affect people with HIV and impedes adherence to diabetes treatment.
b. Describe initiatives implemented based on recommendations: • Collaborate with diabetic members who have a history of non-compliance and develop short-term and long-term goals. • Verbal and/or written education provided to each member. • Assistance with Durable Medical Equipment, Medical & BH appointments. • Coordination of home health services. • Monthly text campaigns for the Diabetic population. • Clinic days for Diabetic members to complete their recommended eye exams. • Clinic days to assist providers with scheduling members for their recommended appointments. • In home retinal eye exams. • Offer Uber transportation when regular Medicaid transportation is not preferred by member. • Outreach Portal to schedule members' appointments. • Monthly circulation of the gaps in care report to the Case Managers in order to target their assigned members. • All CHA members are assigned a case manager upon enrollment to assist with care gaps. • CHA outreach team dedicated to engaging diabetic members in care and coordinate appropriate services based on care gaps. • Provider Education on importance of screening.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • A slight improvement has been observed in diabetic screenings for 2022. The Plan continues monitoring and analyzing outcome data monthly.
d. Identify any barriers to implementing initiatives: • Chronic HIV related inflammation, unwanted side effects and medicine interactions affect diabetes treatment response in people living with HIV. • Lack of understanding health implications secondary to their diabetes diagnosis • Food insecurity can make controlling diabetes especially difficult due to challenges accessing nutritious foods. • Members non-compliant regardless of efforts to provide transportation, schedule appointments and in home services.
e. Identify strategy for continued improvement or overcoming identified barriers: • Weekly interdepartmental meetings for monitoring, review and analyze interventions and track outcome to determine improvement progress. • CHA will also continue to obtain enrollee feedback to better understand the barriers and impact from an enrollee perspective. • Continue to hire and obtain appropriate resources as needed. • Dedicated clinic days targeting comprehensive diabetic care gaps.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why members who access the ED for AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.
Response
a. Describe why this weakness exists: • Adults and adolescents may not recognize the need or readiness to change in terms of their substance use. • Denial is often the first response to the new a new SUD treatment episode. Adults and Adolescents feel • they completed their treatment and fail to see the benefit of follow-up. • Members are not motivated to seek follow-up treatment until they recognize the problems in their life • created by their alcohol and/or drug use. Often, this is not after the first SUD episode. • Social Determinants of Health (SDoH) impact member's ability to stay in treatment or stay focused on sobriety goals if there are risks such as lack of housing or food insecurity. • Members experiencing homelessness may not have updated contact information and the health plan may not have a good phone number or address to contact them. • Inappropriate admissions due to law enforcement initiating a Baker Act admission. Member may have been in crisis at the time of the admission involving alcohol and other drugs (AOD) and not agree they have a problem. Baker Acted individuals are often less likely to comply with follow-up.
b. Describe initiatives implemented based on recommendations: • ENS Alert for Behavioral Health created to better identify members with current or prior BH issues. • The Plan will continue to address and mitigate any barriers linked to this intervention as part of its ongoing evaluation determine the impact of this initiative. • BH Telehealth Initiative • The Plan partnered with two Behavioral Health providers who agreed to perform the following: • Contact every member discharged from a Behavioral Health hospitalization within 24 hours and provide an immediate Telehealth BH visit which will address the Follow-up After Hospitalization for Mental Illness (FUH) 7-Day population. • Contact every member who visited an ED for Mental Illness, Alcohol and Other Drug Abuse or Dependence within 24 hours and provide an immediate Telehealth BH visit which will address the FUM and FUA 7-Day population. • In addition, the Plan did not want to miss the opportunity to impact a related PIP measure (FUH/FUM/FUA 30-Day sub measures) for those members who participate in the pilot. As such, each participant is contacted within 30 days of discharge from the Hospital/ED to schedule a BH Telehealth visit. • All members who participate and complete a TH visit are offered 1 week of free meals as a way to incentivize participation. • BH implemented a Pay for Performance (P4P) initiative MY 2022 with key Inpatient Hospitals to incentivize them for FUH performance. This is continued in 2023 and planned to continue in 2024 with more IP hospitals participating

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increased percentage of 7- and 30- day follow-up visits following a psychiatric ED/Hospital event. • Meeting FUA targets and seeing some improvement in follow-up measures. Some of this improvement is related to the Follow-up After Discharge Assessment (FUADA) process that Simply has improved over the last year. We are seeing impact for MY 2022 and MY 2023
d. Identify any barriers to implementing initiatives: • Timely identification and engagement of members with SMI for a follow-up visit within 7 days of a psychiatric Hospital/ED event. • PHE Impact • It is difficult to ascertain the impact of the PHE on these rates. The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from potentially exceeding its annual goals for HEDIS • BH continues to promote our Telehealth options as well as our FUADA process where we provide a telephone discharge assessment using BH licensed clinicians that meet the FUH, FUM and FUA 7-day or 30-day follow-up appointment via an approved supplemental data process.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to monitor and track utilization of the hospital and ED events for members who participate in these programs. • Continue to use data to evaluate this intervention for overall effectiveness and modify as needed. • Continue to offer Telehealth service options for follow-up appointments and FUADA assessments. • Continue to meet with BH and CHA team to address barriers such as lack of member phone numbers. • Continue the Pay for Performance (P4P) initiative with Inpatient Providers when seems to have shown some improvement in MY 2022. • Continue to meet monthly with participating IP Providers to share their data/results for FUH and Readmission. • Continue to do outreach calls by the Care Management team based on ENS data for Emergency Department discharges and work with the ENS vendor to correct any barriers we are seeing.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* measure.
Response
a. Describe why this weakness exists: • Adults and adolescents may not recognize the need or readiness to change in terms of their substance use. • Denial is often the first response to the new a new SUD treatment episode. Adults and Adolescents feel • they completed their treatment and fail to see the benefit of follow-up.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Members are not motivated to seek follow-up treatment until they recognize the problems in their life • created by their alcohol and/or drug use. Often, this is not after the first SUD episode. • Social Determinants of Health (SDoH) impact member's ability to stay in treatment or stay focused on sobriety goals if there are risks such as lack of housing or food insecurity. • Members experiencing homelessness may not have updated contact information and the health plan may not have a good phone number or address to contact them. • Inappropriate admissions due to law enforcement initiating a Baker Act admission. Member may have been in crisis at the time of the admission involving alcohol and other drugs (AOD) and not agree they have a problem. Baker Acted individuals are often less likely to comply with follow-up.
b. Describe initiatives implemented based on recommendations: • The Plan uses ENS data through a vendor that comes in daily to identity facility admissions. We review for SUD Diagnoses and outreach the member if not already assigned a Case Manager (CM). We call on all Emergency admissions identified on the ENS report. • If there is a lack of a current phone number, we review previous claims or contact recent providers to obtain updated contact information. • The CM refers the member to a Certified Community Behavioral Health Clinic (CCBHC) when possible as they do co-occurring disorders. • The CM can provide resources to address Social Determinants of Health issues such as homelessness. • The Plan may enroll members in its Healthy Behaviors program where members are rewarded for treatment compliance.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Year-Over-Year improvement seen in the Plan's Initiation Phase metric. • Better and quicker identification of members with SUD diagnoses using ENS
d. Identify any barriers to implementing initiatives: • Member readiness to change and motivation to continue their AOD treatment. • Emergency Department data is not managed by the BH plan, and we may not receive timely notifications so that we can start member outreach. • Emergency Department initial diagnosis may not include an SUD. This creates an initial delay in identifying/engaging these members.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to work with ENS vendor to ensure SUD diagnoses are appropriately identified. • Educate Medical and BH providers on IET measure and on the changes to the HEDIS specifications to encourage timely follow-up appointments.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Response
a. Describe why this weakness exists: • Through its behavioral health workgroup, the Plan determined that a significant portion of behavioral health facilities do not utilize the Florida Encounter Notification Service (ENS). As such, this results in a delay in notification of behavioral health discharges for follow-up. In addition, lack of access and availability of behavioral health appointments creates challenges.
b. Describe initiatives implemented based on recommendations: • CHA continues to evaluate existing programs and implement pilots in alignment with Agency-led Statewide collaborative efforts. • Provider-Level: − Bi-weekly interdepartmental meetings with BH partner − Provider webinars for Telehealth expansion − Incorporated BH Telehealth information into PCP toolkit − Pay-for-Performance Offering – Provider upside incentive model to support follow-up after hospitalization for mental illness. − Offering home-based therapy appointments for high-risk members − Continued education on BH services available through the Plan • Member-Level: − Promotion of BH Telehealth (Video and Telephonic) throughout the Plan membership − FAQs on web print promoting BH Telehealth − All members who participate and complete a Telehealth visit are offered 1 week of free meals as a way to incentivize participation. − Member Incentive program for FUH 7-Day and 30-Day Follow-Up − Completion of a new Follow-Up After Discharge form − Ongoing text campaign targeting members for a 7- and 30-day follow-up visit once a behavioral health-related event in the ED or Hospital is identified. − Mental Health Toolkit containing various resources and education. − Health Risk Assessment (HRA) BH Focus – members identified as having BH needs on the HRA are prioritized for outreach to ensure all member needs are appropriately addressed. − Aftercare Program - Outreach to recently discharged members − Ensure follow-up appointment is scheduled within 7- and 30-days post discharge. − Assess post discharge needs. − Provide referrals (if needed) − Address barriers to appointment compliance − Provide member education. • System-Level: − ENS Notification Enhancements (SMART alerts) − Customized alerting based on the PIP's three performance indicators (FUH, FUM, FUA)
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Statistically significant improvement is seen in the Plan's HEDIS FUH rate when comparing MY 2022 to MY 2021 • Improved coordination of care • A faster and more efficient data exchange process resulting in faster and more effective follow-up care. • Improvement in Access and Availability for Providers

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
d. Identify any barriers to implementing initiatives: • Lack of timely identification of members with a psychiatric Hospital/ED event • Lack of member incentive to see a BH provider within 7 and/or 30 days of discharge • Socio-economic factors (i.e., homelessness, lack of contact information, etc.) • PHE Impact: − It is difficult to ascertain the impact of the PHE on these rates. The overall impact of the pandemic on mental health, worsened by the apprehension over in-person visits and limited socialization has hindered the Plan from potentially exceeding its annual goals for HEDIS
e. Identify strategy for continued improvement or overcoming identified barriers: • Continued provider and member education • Further promote and expand on the use of Telehealth. • Continue to find creative ways to incentivize members to follow-up with a BH provider within 7 days of ED/Hospital event. • Continue to address and mitigate any barriers identified through ongoing monitoring and evaluation. • Continue to analyze the impact of interventions implemented through the PDSA process
HSAG Assessment

Molina-S-SMI

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • Many non-urgent services were cancelled or postponed, leading to delays in preventative and ambulatory care. • Healthcare practice locations experienced closures of certain locations and reduction in staffing levels. • Unable to locate members to assist with scheduling appointments
b. Describe initiatives implemented based on recommendations: • An increase in the number of provider engagements from 10 to 12 per month and on-going member outreach through calling campaigns was reinforced. • Introductions of Molina's Champions Program and a Diabetes Nutrition Counseling referral to broaden member outreach and reminder of annual visits. • Targeted outreach for high-risk members, such as those who have not had an annual visit in two years or more. This collaboration includes efforts from newly contracted vendors to provide in home visits, Healthcare Services, and Case Management to evaluate reasons for abstaining from annual visits. • The AAP measure has been incorporated in Molina's Behavioral Health Provider Pay for Quality program. Providing a financial incentive of $50 for each member seen over the benchmark, with a goal of closing the gap in preventive care and motivating providers to engage in members annual visits
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • An increase in performance was observed following the collaboration of a new vendor assistance program aimed at identifying missing member phone numbers. Out of the 11,391 initially unavailable member phone numbers, 5,695 were successfully located.
d. Identify any barriers to implementing initiatives: • Staffing shortages and the closure of certain provider locations. This placed limitations on the providers effectively collaborating with managed care and providing appointments for the members to be seen. • Inaccurate or incomplete member demographics to outreach and assist them with education and appointment setting
e. Identify strategy for continued improvement or overcoming identified barriers: • Improve our outreach methods by introducing text messaging for convenient engagement with members. • Continue telephonic outreach efforts and educational programs to connect with members and provide valuable information to encourage involvement in their care. • Collaborate with community resources, including local Health Departments, hospitals, and YMCA for the local educational programs offered.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Identify best practices for ensuring adolescents receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of adolescents not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.
Response
a. Describe why this weakness exists: • Lack of communication on the importance of immunizations to both healthcare providers and parents. Often, the focus is primarily on vaccines mandated by the school board, leading to a gap in understanding the importance of a comprehensive vaccination schedule. • For children in the SMI population, parents and guardians often have to prioritize their focus on the child's behavioral health concerns before preventive care.
b. Describe initiatives implemented based on recommendations: • Provider focused education programs aimed towards effectively educating parents about the importance of vaccinations.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • With the implementation of the initiatives mentioned above, we have observed a decrease from the IMA shots from 2021 to 2022. The SMI decreased by 1.21%
d. Identify any barriers to implementing initiatives: • Parents or legal guardian of the member refusing vaccines or require education on the importance of a vaccination schedule.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continued education for both the providers and parents about the importance of vaccines to lead them to make informed decisions in favor of their children healthcare.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine barriers to child members receiving BMI documentation, counseling for nutrition, and counseling for physical activity. Upon identification of a root cause, implement appropriate interventions to improve the performance related to *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (two of three indicators).
Response
a. Describe why this weakness exists: • Outdated or inaccurate contact information for parents or guardians of pediatric members creating delays with scheduling timely appointments. • Parents or guardians of members may prioritize Behavioral Health needs before preventative care

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Barriers with coding for services rendered during pediatric well visits, few EMR systems do not auto populate BMI measure within annual well care visit.
b. Describe initiatives implemented based on recommendations: • Introduction of a new vendor to assist with identifying and locating missing member phone numbers to enhance the accuracy of member contact information for pediatric members, helping to provide improved communication and appointment scheduling. • Increase of monthly provider engagements from 10 to 12 per month; allowing the Quality Department to strengthen education efforts on best practices within provider groups, and a collaborative approach to addressing gaps in care. • Issuing updated tip sheets to provider groups, offering clear guidance on accurate coding for various billing procedures, with the aim to minimize errors in documentation and billing procedures. • Expanding the outreach efforts of the Health Educator team to include pediatric members, specifically targeting child well visits.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • With the implementation of the initiatives mentioned above, we have observed an increase with pediatric members attending their well visits. (telehealth expansion) From 2021 to 2022 child members receiving BMI documentation increased by 7.79%, counseling for nutrition increased by 8.76%, and counseling for physical activity increased by 12.16%.
d. Identify any barriers to implementing initiatives: • The performance of our new vendor to locate member phone numbers is dependent on obtaining accurate details about the parent or guardian of the member to be contacted successfully.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to educate our provider groups to reinforce the importance of accurate documentation for all services provided during the visit. • Increase efforts of the Health Educator team, with a focus on our pediatric members with accurate contact information.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to identify barriers to children receiving well-care visits. Upon identification of any root causes contributing to these gaps in care, implement appropriate interventions to improve the use of evidence-based practices related specifically to *Child and Adolescent Well-Care Visits—Ages 3–11 Years, Ages 12–17 Years, Ages 18–21 Years,* and *Total.*
Response
a. Describe why this weakness exists: • Outdated and inaccurate contact information for their parents or guardians. The effectiveness of service delivery relies heavily on accurate contact information to ensure timely scheduling of appointments for pediatric members. • Improper coding for services rendered during a single visit causing inaccurate documentation or the omission of the needed service codes with billing.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• SMI members are eligible to become a member starting at age 3, many parents must prioritize their child's behavioral health needs. • Many children with SMI population are not actively engaged in sports/activities that require an annual physical.
b. Describe initiatives implemented based on recommendations: • Introduction of a new vendor to assist with identifying and locating missing member phone numbers to enhance the accuracy of member contact information for pediatric members, helping to provide improved communication and appointment scheduling. • Increase of monthly provider engagements from 10 to 12; allowing the Quality department to strengthen education initiatives on best practices within provider groups, and a collaborative approach to addressing gaps in care. • Issuing updated tip sheets to provider groups, which offer clear guidance on the accurate usage of codes for various billing procedures, aiming to minimize errors in documentation and billing procedures. • Expanding the outreach efforts of the Health Educator team to include pediatric members, specifically targeting child well visits. • Offer gift cards to further incentivize members to attend appointments.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • With the implementation of the initiatives mentioned above, we have observed an increase with pediatric members attending their well visits. From 2021 to 2022 children receiving well-care visits increased by 2.09%.
d. Identify any barriers to implementing initiatives: • The performance of our new vendor to locate member phone numbers is dependent on obtaining accurate details about the parent or guardian of the member to be contacted successfully. The primary barrier that has been identified is the accuracy of the contact information that is gathered.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue the education of provider groups to reinforce the importance of accurate documentation for all services provided during the visit. • Further increase the efforts of the Health Educator team, with a focus on our pediatric members with accurate contact information.
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why women are not receiving breast or cervical cancer screenings. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving breast and cervical cancer screenings.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Response
a. Describe why this weakness exists: • Incorrect or unavailable member contact information • Members often prioritize their behavioral health concerns before preventative care, leading to a decline in screenings.
b. Describe initiatives implemented based on recommendations: • Increase of monthly provider engagements from 10 to 12 per month; allowing the Quality Department to strengthen education efforts on best practices within provider groups, and a collaborative approach to addressing gaps in care. • Provider fax campaign during October to educate and bring awareness to our providers with open gaps for BCS. • Health Educators provide outreach to members to bring awareness on the importance of regular screenings and assist with scheduling appointments.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
d. Identify any barriers to implementing initiatives: • Outdated/Incorrect member demographic information. • Members not attending scheduled appointments
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to support and incentivize members to set appointments with targeted call campaigns for prevention, screenings, and all women's measures.
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. Analyze data and consider whether there are disparities within the plan's populations that contributed to lower access to care. Upon identification of a root cause, implement appropriate interventions to improve quality of, access to, and timeliness of prenatal and postpartum care.
Response
a. Describe why this weakness exists: • High-risk members with drug and opioid use, housing instability and co-morbidities/Dual Dx that result in insufficient prenatal care. • Lack of notification from the member to the health plan on their pregnancy status, and/or a lack of notification of pregnant members from the providers to the health plan.
b. Describe initiatives implemented based on recommendations: • Outreach to new members identified as pregnant, including additional initial telephonic outreach attempts, a Member Location Unit (MLU) and Community Connectors for community visits in attempt to contact the member as early as possible to coordinate prenatal care, complete prenatal risk assessments and coordinate referral to any identified needs that could impact birth outcomes.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Enhanced Healthy Behaviors programs to include interventions and incentives related to participation in prenatal substance use programs provided by Healthy Start and substance use treatment. • Implemented Provider outreach and education regarding early identification of substance use in pregnant members and appropriate referral and treatment for substance use. • Developed a protocol that all pregnant members in the SMI population are considered High-Risk and assigned to a case manager.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For the PPC: Prenatal SMI Population, the plan is trending 4.11% higher YOY and for PPC: Postpartum, we are trending 6.77% higher YOY.
d. Identify any barriers to implementing initiatives: • Providers not notifying the plan of recent pregnancies. • Homelessness impacting accessibility and continuity of care. • Socioeconomic challenges related to homelessness and poverty • Health Literacy • Teen Pregnancy and specialized support and interventions they need. • Inaccurate or incomplete contact information for members and providers
e. Identify strategy for continued improvement or overcoming identified barriers: • Increase awareness with providers on open gaps for both PPC measures during engagements with assistance from network to inform providers on the importance of closing these care gaps and the need for timely comprehensive postpartum and prenatal care. • Work closely with Case Management specifically for the SMI population to identify and address SDOH and provide immediate and ongoing support for health and social challenges.
HSAG Assessment
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members with persistent asthma do not have appropriate medication management. Upon identification of a root cause, implement appropriate interventions to improve performance for the *Asthma Medication Ratio—Total* measure.
Response
a. Describe why this weakness exists: • Proximity to nearest pharmacy limiting timely access to medications • Timeliness of medication pick-up impacting consistent adherence to treatment plan by provider • Insufficient education or awareness of the importance of the treatment regimen and maintaining asthma care along with their behavioral health diagnosis.
b. Describe initiatives implemented based on recommendations: • We have implemented a monthly calling campaign aimed at serving two purposes. First, being an educational centered reminder to members about the importance of medication adherence for their asthma. To ensure continuous support and access, the campaign also assists the member with scheduling necessary follow-up appointments with their providers.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There has been an increase for our SMI population from 55.39% to 62.86% and a slight increase for MCD from 79.69% to 80.93% during CY 2022.
d. Identify any barriers to implementing initiatives: • Heath literacy among members regarding their diagnosis and the importance of adhering to prescribed treatment and medication management for asthma. • Difficulties getting in contact with the members due to incorrect contact demographics to remind them of their medication pick-ups • Instances where Molina serves as a secondary payor, which delays coverage until primary insurance is utilized first, affecting timely access to medication for our members. • Insufficient availability of providers in more rural regions within the state.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue telephonic outreach to members to remind and encourage timely medication pick-ups and importance of following their treatment plan. • Developing educational materials designed for members, aiming to reinforce timeliness of medication pick-up and follow-up care with their provider • Strengthen communication channels between Behavioral Health providers and Primary Care to ensure better support for members managing asthma alongside behavioral health conditions. • Utilize telehealth between members and their BH providers during monthly check-in appointments to reinforce patient education and facilitate follow-up care. This may also be beneficial for members who live in more rural areas across the state.
HSAG Assessment
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance for the *Comprehensive Diabetes Care* measure.
Response
a. Describe why this weakness exists: • The complexities for members on their behavioral health diagnosis, effectively communicating with their PCP about treatment with their BH provider and any antipsychotic medications they have been placed on, a lack of education on the implications of their diagnosis. • Members can be difficult to outreach (e.g., phone numbers and addresses) and engage with them, or bring them into the clinical setting for services. • Certain screenings for Comprehensive Diabetic Care measures, specifically eye exam and A1c screening, require members to attend an in-person appointment or obtain a referral for a specialist.
b. Describe initiatives implemented based on recommendations: • Implementation of Molina's Champions Program, with a focus on addressing blood pressure concerns, led to successful outreach efforts targeting members who fall into a Diabetes or Hypertension measure.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• A statewide resource list was created for our members enrolled in the Champions Program and diagnosed with diabetes that provides accessible and targeted support for managing diabetes. The resource list contains facilities to access Diabetic and Nutritional Counseling services at local hospitals, health departments, and YMCA (Young Men's Christian Association).
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
d. Identify any barriers to implementing initiatives: • Staffing shortages and closure to certain locations has placed limitations for providers to collaborate effectively in member outreach efforts. • Lack of member accurate member demographics. • Not all providers perform A1c testing and retinal eye exam in their office and depend on the member to attend a specialist appointment after a referral is made.
e. Identify strategy for continued improvement or overcoming identified barriers: • Improve our outreach methods by introducing text messaging for convenient engagement with members. • Continue telephonic outreach efforts and education programs to connect with members and provide valuable information to encourage involvement in their care. • Continue provider education about eyecare vendor and laboratories that are contracted with Molina.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.
Response
a. Describe why this weakness exists: • Inaccurate or missing member demographics to successfully outreach after discharge. • Members not adhering to scheduled appointments
b. Describe initiatives implemented based on recommendations: • The Specialty Plan has developed the Bridge to Home form for BH inpatient facilities. This form is requested from facilities as a means to capture member's discharge plan including medications and 7 Day follow-up appointment details. • The Specialty Plan Care Coordinator confirms if a member is linked to a PCP or BH provider, assist with scheduling of timely follow-up appointment within 7 days of discharge, schedule transportation if needed and call member to verify compliance w/appointment
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During CY 2022, Molina reported a 5% increase in compliance of members receiving timely follow up after implementing the Bridge to Home program.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
d. Identify any barriers to implementing initiatives: • Member's lack of adherence to schedule appointments, demographic issues contacting 55% of members once discharged from facility. • Inconsistency of Hospitals to discharge members with a prior scheduled appointment.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to identify and follow-up on all BH inpatient and emergency discharges to support access to 7 day follow up appointments.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* measure.
Response
a. Describe why this weakness exists: • Primary Care doctors are unaware of their ability to help close behavioral health gaps in care for their members after discharge. • Inconsistency of Hospitals to discharge members with a prior scheduled appointment.
b. Describe initiatives implemented based on recommendations: • MFL has conducted numerous provider engagements, between one and three visits per year to a multitude of distinct provider offices, that have targeted behavioral health members with previous open gaps in care. • The Specialty Plan utilizes daily ENS notifications to follow-up with members identified with an inpatient facility or emergency room discharge. Identified members are assigned to the Care Transitions team and/or assigned care manager for follow-up. Assigned care coordinator or care manager will outreach identified members to assist with scheduling 7 Day follow-up appointments and coordinate transportation if necessary. • MFL P4Q (Behavior Health Pay for Quality) program incentivizes BH health providers to invest in best practices and tools to effectively monitor member progress and collaborate with MFL and Primary Care Providers (PCPs) to support members in achieving their best possible health outcomes.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
d. Identify any barriers to implementing initiatives: • Members not attending previous scheduled appointments • Inaccurate or not current demographic information for members
e. Identify strategy for continued improvement or overcoming identified barriers: • Education and outreach to raise awareness on the accessibility of behavioral health services to high utilization.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • Difficulty outreaching all identified members due to lack of current demographic information. • Inconsistency of hospitals discharging members with a prior scheduled appointment for follow-up. • Member's lack of adherence to scheduled appointments.
b. Describe initiatives implemented based on recommendations: • Monitoring internal and external resources to gain additional data and demographics of our members. Together with data from external public health services like Quest, Mosaic, and CVS, these sources are combined into a single report that draws from Molina's own databases, which include QNXT, ClaimSphere, and CCA. • Introduced a new vendor assistance program aimed at identifying missing member phone numbers for targeted outreach. • Implemented use of LACE scoring to identify members at high risk of readmission. Members with high risk of readmission are identified for Care Transitions program and 30-day follow-up. These members were provided with follow-up over a 30-day period.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The Molina Transition of Care team has successfully engaged 2,878 members by reaching out to 3,905 members during CY 2022.
d. Identify any barriers to implementing initiatives: • Hospitals' failure to consistently discharge patients with a scheduled appointment with their provider. • Lack of Primary Care Physicians' awareness about their ability to close gap for members discharged from the Emergency Department
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to utilize care coordinators to verify if a member is associated with a PCP or BH provider, and to help arrange a follow-up appointment within the window. • Continue to identify and follow-up on all BH inpatient discharges to support access to 7 day follow up appts.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members with schizophrenia or bipolar disorder and on antipsychotic medication are not receiving diabetes screening. Upon identification of a root cause, implement appropriate interventions to improve the performance related to *Diabetes*

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications measure.

Response

a. Describe why this weakness exists:
- Insufficient communication between Behavioral Health (BH) providers and Primary Care Providers (PCP)
- The overall complexities of the members behavioral health diagnosis along with other comorbidities.
- Effectively communicating with their PCP about treatment with their BH provider and any antipsychotic medications they have been placed on, a lack of education on the implications of their diagnosis, and a sometimes a transient lifestyle.

b. Describe initiatives implemented based on recommendations:
- Implementation of Pay for Quality incentives for providers and member incentives such as gift cards.
- Implementing a quarterly reporting system for all members falling into a Comprehensive Diabetes Measure (CDC, SAA, and SSD). The findings from these reports are shared with their assigned providers, Case Management and Healthcare Services to ensure a proactive approach for care.
- Health Educators assist our members with scheduling their annual visits and encourages open discussions with their PCP regarding all medications they are taking.
- Leveraging pharmacy data to identify Behavioral Health providers who are prescribing antipsychotic medication and ensuring that relevant information is shared among the members healthcare team.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- N/A

d. Identify any barriers to implementing initiatives:
- Lack of effective communication between Behavioral Health providers and Primary Care providers.
- Insufficient member demographic information available on where the member is accessing Behavioral Health services or who their provider is.
- Members prioritize their immediate behavioral health concerns before addressing preventative care needs.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Continue quarterly reporting of members falling within the measures for Comprehensive Diabetic Care, SAA and SSD and share those findings with their assigned providers, Case Management, and Healthcare Services Teams.
- Enhance reporting to include monthly notifications for providers, Case Management, and Healthcare Services teams for all members with a diabetes diagnosis and may also be prescribed antipsychotic medications, allowing for targeted interventions to address any potential barriers the member faces.
- Actively refer members to local Diabetes and Nutrition counseling and support services.

HSAG Assessment

Sunshine-S-CW

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of preventive and ambulatory services due to the fear of exposure.
b. Describe initiatives implemented based on recommendations: • Sunshine Health is promoting member utilization of a 24/7 telemedicine program through the Teladoc health app. Members will be mailed a flyer promoting Teladoc use once the flyer has received AHCA approval. • The Concierge Team calls members with care gaps and helps them schedule appointments.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • None identified.
d. Identify any barriers to implementing initiatives: • Some members may not have access to smart phones or devices. • Bad addresses due to frequent residence changes. • Member no-show rates are high after appointments are made.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management assists with scheduling medical appointments, as appropriate. • MyHealthDirect is utilized to enhance efforts to schedule preventive health appointments. • Sunshine Health continues work to expand network access to Urgent Care and Minute Clinics.
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. Analyze data and consider whether there are disparities within the plan's populations that contributed to lower access to care. Upon identification of a root cause, implement appropriate interventions to improve quality of, access to, and timeliness of prenatal and postpartum care.
Response
a. Describe why this weakness exists: • Providers are incorrectly coding positive pregnancy tests. • Members aren't aware of pregnancy or hide pregnancy from parent/guardian until late in prenatal care. • Members are not returning for postpartum care because they do not understand the importance.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • OB/GYN Incentive Program to incentivize OB/ GYNs for each care gap they close. • Utilization of OB Care Gap Report to conduct targeted member and provider education. • Quality Practice Advisors conduct virtual and in-person Provider visits to improve rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS PPC-Pst measure rate increased from 66.67% for CY 2021 to 72.16% for CY 2022. • The HEDIS PPC-Pre measure rate increased from 61.76% for CY 2021 to 68.04% for CY 2022.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* measure.
Response
a. Describe why this weakness exists: • Member refusal. • Not a perceived problem by member family. • Stigma of mental health care.
b. Describe initiatives implemented based on recommendations: • The Concierge Team calls members with care gaps and helps them schedule appointments. • Behavioral Health Incentive Program initiated in March 2023 to incentivize providers for closing care gaps.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • Incorrect member contact information. • Member no-show rates are high after appointments are made. • Provider incorrect coding.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management assists with scheduling medical appointments, as appropriate. • Continued provider education by Quality Practice Advisors.
HSAG Assessment • NA—No results available at time of reporting.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:

Recommendations for Behavioral Health Domain

HSAG recommended the following:

- Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.

Response

a. Describe why this weakness exists:
- Follow-up visits are not scheduled before member leaves inpatient facility.
- Member refusal.
- Not a perceived problem by member family.
- Member readmission.

b. Describe initiatives implemented based on recommendations:
- Case Management follow-up with member after hospitalization for mental illness to help schedule follow-up care.

c. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- Results will be evaluated after the performance year has ended.

d. Identify any barriers to implementing initiatives:
- Members contact information is sometimes not correct.
- Members do not answer phone or return messages.

e. Identify strategy for continued improvement or overcoming identified barriers:
- Case Management makes multiple attempts to contact member and a letter is mailed to the member when unable to reach.

HSAG Assessment

Recommendations for Behavioral Health Domain

HSAG recommended the following:

- Conduct a root cause analysis to determine why members who access the ED for AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.

Response

a. Describe why this weakness exists:
- Follow-up visits are not scheduled before member leaves ED.
- Member refusal.
- Not a perceived problem by member family.
- Member readmission.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • Case Management follow-up with member after ED visits for AOD abuse or dependence to help schedule follow-up care. • BH provider care gap reports.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS FUA measure increased from 0.0% for CY 2021 to 20.16% for CY 2022.
d. Identify any barriers to implementing initiatives: • Members contact information is sometimes not correct. • Members do not answer phone or return messages.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management makes multiple attempts to contact member and a letter is mailed to the member when unable to reach.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members with a diagnosis of major depression who were newly treated with antidepressant medication did not remain on their antidepressant medications. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Antidepressant Medication Management—Effective Continuation Phase Treatment* measure.
Response
a. Describe why this weakness exists: • Members are concerned about the perceived stigma associated with taking antidepressants. • Members stop taking antidepressants when they feel better. • Members cannot tolerate the side effects. • Some members didn't want to admit they needed something to help them feel normal. • Family thinks the member needs to 'snap out of it' and deal with things on their own. • Some members didn't want a medication to define them. • Some members didn't feel the medication was needed.
b. Describe initiatives implemented based on recommendations: • The Concierge Team calls members with care gaps and helps them schedule appointments. • Utilization of Behavioral Health Gap Report to conduct targeted member and provider education. • Quality Practice Advisors conduct virtual and in-person Provider visits to improve rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • Incorrect member contact information. • Member no-show rates are high after appointments are made.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management assists with scheduling medical appointments, as appropriate.
HSAG Assessment

Sunshine-S-SMI

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of preventive and ambulatory services due to the fear of exposure.
b. Describe initiatives implemented based on recommendations: • Sunshine Health is promoting member utilization of a 24/7 telemedicine program through the Teladoc health app. Members will be mailed a flyer promoting Teladoc use once the flyer has received AHCA approval. • The Concierge Team calls members with care gaps and helps them schedule appointments.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • Some members may not have access to smart phones or devices. • Bad addresses due to frequent residence changes. • Member no-show rates are high after appointments are made.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management assists with scheduling medical appointments, as appropriate. • MyHealthDirect is utilized to enhance efforts to schedule preventive health appointments. • Sunshine Health continues work to expand network access to Urgent Care and Minute Clinics.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Identify best practices for ensuring children and adolescents receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children and adolescents not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of preventive and ambulatory services due to the fear of exposure.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • Immunization Tool Kit - Small practices with decent member volumes but poor vaccine compliance rates were targeted to receive the Immunization Tool kit in 2022. The Quality Practice Advisor (QPA) team met with these practices and assisted with identifying a vaccine champion in the office, posting vaccine policies, and preparing a vaccine tool kit (this kit included resources from the CDC, Pfizer, Merck, and the American Cancer Society). The office was also assisted to create an alert system for vaccines that were due and the QPA met monthly with the vaccine champion to ensure measures were implemented. • Shoes for Shots (aka Healthy Steps Program) - Partnered with Community Medical Group (CMG) to provide free shoes and backpacks to kids who came and received vaccines. CMG advertised the event via email, radio, posters, social media, and tv ads.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Of the 22 practices that were targeted for the Immunization Toolkit: 20 practices improved CIS Combo 3, 17 practices improved for CIS Combo 10, 19 practices improved for IMA Combo 1, and 19 practices improved for IMA Combo 2. • Shoes of Shots: Almost 200 members received vaccines.
d. Identify any barriers to implementing initiatives: • Immunization Tool Kits: 2 practices lacked baseline data to determine change. • Shoes for Shots: Since members did not have to RSVP, the shoe size had to be obtained, and members had to return a week later to pick up the shoe order.
e. Identify strategy for continued improvement or overcoming identified barriers: • If Shoes for Shots is continued, additional organizational partnerships will be explored.
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why women are not receiving breast or cervical cancer screenings. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving breast and cervical cancer screenings.
Response
a. Describe why this weakness exists: • Lack of transportation to mammography screening. • Fear of bad news or pain from the mammogram. • Lack of a recommendation from a health care provider to get mammography screening.
b. Describe initiatives implemented based on recommendations: • Mammograms provided by 3D Mobile Mammography. Mammograms are performed by a board-certified fellowship-trained breast imaging radiologist. The screening takes about 10 minutes and results are available within 24 hours. • OB/GYN Incentive Program to incentivize OB/GYNs for each breast cancer screening care gap they close.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Quality Practice Advisors conduct virtual and in-person Provider visits to educate providers and improve breast cancer screening rates. • Members receive MyHealthPays reward of $20 for completing an annual Mammogram Screening.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS BCS measure rate increased from 43.93% for CY 2021 to 45.55% for CY 2022.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment
Recommendations for Women's Care Domain
HSAG recommended the following: • Consider the health literacy of the population served, as well as their capacity to access prenatal and postpartum care. Analyze data and consider whether there are disparities within the plan's populations that contributed to lower access to care. Upon identification of a root cause, implement appropriate interventions to improve quality of, access to, and timeliness of prenatal and postpartum care.
Response
a. Describe why this weakness exists: • Providers are incorrectly coding positive pregnancy tests. • Members aren't aware of pregnancy or hide pregnancy from parent/guardian until late in prenatal care. • Members are not returning for postpartum care because they do not understand the importance.
b. Describe initiatives implemented based on recommendations: • OB/GYN Incentive Program to incentivize OB/ GYNs for each care gap they close. • Utilization of OB Care Gap Report to conduct targeted member and provider education. • Quality Practice Advisors conduct virtual and in-person Provider visits to educate and improve prenatal and postpartum care rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS PPC-Pst measure rate increased from 58.64% for CY 2021 to 68.13% for CY 2022. • The HEDIS PPC-Pre measure rate increased from 67.15% for CY 2021 to 69.34% for CY 2022.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members with persistent asthma do not have appropriate medication management. Upon identification of a root cause, implement appropriate interventions to improve performance for the *Asthma Medication Ratio—Total* measure.
Response
a. Describe why this weakness exists: • Substance abuse issues. • Lack of education • Homelessness or other SDOH related needs
b. Describe initiatives implemented based on recommendations: • Contracted with VRI to provide remote monitoring for members diagnosed with persistent asthma. • Developing Member Adherence call program to perform outbound calls to targeted at risk members to remind them that they are due for a refill of their target medication(s).
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment • NA, no results available at time of reporting.
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members are not receiving timely recommended screenings for diabetes. Upon identification of a root cause, implement appropriate interventions to improve performance for the *Comprehensive Diabetes Care* measure.
Response
a. Describe why this weakness exists: • The PHE resulted in members avoiding the use of MD offices due to the fear of exposure. • Endocrinologists did not have visibility into the care gaps of the members they were seeing. • Member noncompliance due to competing personal demands.
b. Describe initiatives implemented based on recommendations: • Endocrinology Incentive Program initiated in March 2023 to incentivize providers for closing care gaps. • Members receive MyHealthPays reward of $25 for completing annual Comprehensive Diabetes Care. • Utilization of Care Gap Report to conduct targeted member and provider education. • Quality Practice Advisors conduct virtual and in-person Provider visits to improve rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
d. Identify any barriers to implementing initiatives: • None identified.
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment • NA—No results available at time of reporting.
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why members who access the ED for mental illness or AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plans increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.
Response
a. Describe why this weakness exists: • Follow-up visits are not scheduled before member leaves ED. • Member refusal. • Not a perceived problem by member family. • Member readmission.
b. Describe initiatives implemented based on recommendations: • Case Management follow-up with member after ED visits for mental illness or AOD abuse or dependence to help schedule follow-up care. • BH provider care gap reports.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS FUA measure increased from 6.93% for CY 2021 to 18.08% for CY 2022. • The HEDIS FUM measure increased from 23.14% for CY 2021 to 23.71% for CY 2022.
d. Identify any barriers to implementing initiatives: • Members contact information is sometimes not correct. • Members do not answer phone or return messages.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management makes multiple attempts to contact member and a letter is mailed to the member when unable to reach.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment*—*Engagement of AOD Treatment—Total* measure.
Response
a. Describe why this weakness exists: • Member refusal. • Not a perceived problem by member family. • Stigma of mental health care.
b. Describe initiatives implemented based on recommendations: • The Concierge Team calls members with care gaps and helps them schedule appointments. • Sunshine Health contracted with the Pyx Health program to provide members with 24/7 support and companionship. • Behavioral Health Incentive Program initiated in March 2023 to incentivize providers for closing care gaps.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Results will be evaluated after the performance year has ended.
d. Identify any barriers to implementing initiatives: • Bad addresses due to frequent residence changes. • Member no-show rates are high after appointments are made. • Provider incorrect coding.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management assists with scheduling medical appointments, as appropriate. • MyHealthDirect is utilized to enhance efforts to schedule preventive health appointments. • Continued provider education by Quality Practice Advisors.
HSAG Assessment • NA—No results available at time of reporting.
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • Follow-up visits are not scheduled before member leaves inpatient facility. • Member refusal. • Not a perceived problem by member family. • Member readmission.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • Case Management follow-up with member after hospitalization for mental illness to help schedule follow-up care.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS FUH measure increased from 17.86% for CY 2021 to 25.08% for CY 2022.
d. Identify any barriers to implementing initiatives: • Members contact information is sometimes not correct. • Members do not answer phone or return messages.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management makes multiple attempts to contact member and a letter is mailed to the member when unable to reach.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members with schizophrenia or bipolar disorder and on antipsychotic medication are not receiving diabetes screening. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure.
Response
a. Describe why this weakness exists: • Members going to behavioral health providers and not their PCPs and BH provider is then not performing diabetes screening.
b. Describe initiatives implemented based on recommendations: • BH provider care gap reports. • Contracted with Myhomedoctor to provide PCP visits in a member's home. • Quality Practice Advisors conduct virtual and in-person Provider visits to improve rates. • The Concierge Team calls members with care gaps and helps them schedule appointments.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The HEDIS SSD measure increased from 74.29% for CY 2021 to 76.03% for CY 2022
d. Identify any barriers to implementing initiatives: • Bad addresses due to frequent residence changes. • Member no-show rates are high after appointments are made.
e. Identify strategy for continued improvement or overcoming identified barriers: • Case Management assists with scheduling medical appointments, as appropriate. • MyHealthDirect is utilized to enhance efforts to schedule preventive health appointments.
HSAG Assessment

Managed Medical Assistance Plans

AmeriHealth-M

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • Providers have indicated there are staffing shortages, leading to appointment availability shortages. Members are not able to make an appointment for several months at times. The time between scheduling and completing the appointment can affect changes in priorities of the member.
b. Describe initiatives implemented based on recommendations: • Quality has strategy meetings with providers to discuss possible interventions to assist in this situation. When available, providers have discussed telehealth options although it must be noted many providers are resistant to holding telehealth appointments now that the public health emergency has expired. Best practices are shared with the provider including making follow-up appointments before the member leaves the office, sending reminders to members to attend appointments, after hours appointment availability being offered, and partnerships with the plan to send messages. Clinic days were established with a provider where appointments were made on a Saturday, members were informed of incentives, reminder calls and texts were sent yet members still failed to come to the appointments. A health equity project is underway specifically for our members aged 0-15 months identified as black/African American. The data suggests these members specifically have a disparity when it comes to accessing care. Quality has focused on these specific members and are actively working with providers to make the access for these members more equitable.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For the health equity project, we have seen an increase in rate from the baseline. The goal is to have an overall improvement of 5% from baseline in the measure, but more specifically movement in the targeted group. To date, we are trending towards a better overall rate for end of year although skeptical we will hit the 5% improvement as we started late in the year and the trend does not suggestion a 5% improvement.
d. Identify any barriers to implementing initiatives: • Member contact information is an ongoing issue. There are many members with no contact information on file, phone numbers no longer in service and addresses no longer current. This creates an obstacle for both the plan and the provider to contact the member and establish a relationship to influence behavior change. The health equity project was not enacted until late July, leaving less than a full year to address identified barriers.
e. Identify strategy for continued improvement or overcoming identified barriers: • The health equity project was not put into place until late in July leaving less than a year to implement change. We have learned some valuable lessons from the data which can be implemented in the future.
HSAG Assessment
• NA—No results available at time of reporting.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members with diabetes are not receiving eye exams (retinal). Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving eye exams (retinal).
Response
a. Describe why this weakness exists: • Providers have indicated there are staffing shortages, leading to appointment availability shortages. Members are not able to make an appointment for several months at times. The time between scheduling and completing the appointment can affect changes in priorities of the member.
b. Describe initiatives implemented based on recommendations: • Members receive text messages reminding them they have outstanding services to address. ACFL also has been sending automated messages to members to remind them to complete open gaps in care. The Case Management team also works with members engaged in Case Management to address open gaps in care. The ACFL Quality team has been meeting with high volume providers to go over the members in need of services and sharing best practices to get them in for appointments. Additionally, ACFL has looked closely at the race, ethnicity, and language data to identify any possible disadvantaged groups. It was noted a group of members who were Spanish speaking and residing in Miami county were not obtaining services. ACFL Community Health Navigator (CHN) reached out to these members and attempted to schedule appointments for services. ACFL holds quarterly HEDIS® 101 training with providers to share information on improving HEDIS® scores. Eye exams is one of the measures covered during the training where best practices are shared to improve the rates.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Members were not interested in making appointments with the CHN's assistance. They were willing to listen to the message and reminded to take action on their health.
d. Identify any barriers to implementing initiatives: • Attempts to contract with Premier for additional support were not successful due to lack of response from vendor. Member contact information was either not available or no longer accurate.
e. Identify strategy for continued improvement or overcoming identified barriers: • ACFL is looking to partner with a vendor to assist in getting members in for these important services. Attempts to secure these vendor contract earlier in the year will be attempted in 2024. Clinic days with keys providers are being slowly worked back into the improvement plan due to the reduced work force in many offices. Staffing challenges exist making it difficult to hold ACFL specific clinic days.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total* measure.
Response
a. Describe why this weakness exists: • Members had a challenge in accessing services due to provider shortages and overall access issues resulting from the public health emergency. This created a greater demand for telehealth services. High volume providers were identified for follow-up.
b. Describe initiatives implemented based on recommendations: • BraveHealth is a behavioral health telehealth provider with a full continuum of services ACFL contracted with starting December 2021. The partnership with BraveHealth has allowed members to access their services in a remote capacity thereby meeting members where they are in their health care journey. BraveHealth allows for services to be completed in a timely manner with little to no wait for members. Additionally, ACFL worked closely with high volume providers to discuss opportunities to partner on activities supporting the members ability to follow-up. Additionally, ACFL has been closely monitoring members with potentially preventable events (PPEs) and outreaching to them to make them aware of the telehealth services being offered.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • BraveHealth was able to close the gap for 46% of our members referred to them for BH FU services. This was not only for the AOD members but provides an indication of their ability to meet the needs of the ACFL members. ACFL identified members with a PPE in the recent past and sent education to them to redirect them from the emergency room. The results indicated around 80% of members with a PPE did not have another PPE after the mailing was completed.
d. Identify any barriers to implementing initiatives: • BraveHealth had some issues meeting the needs of the volume of members for a short period of time. They were able to hire additional staff and have since returned to meeting the 7-day follow-up time frame. Additionally, ACFL continues to be challenged with current contact information for members. This makes it challenging to engage with members and meet timelines on follow-up appointments.
e. Identify strategy for continued improvement or overcoming identified barriers: • ACFL continues to meet with the high-volume providers in the network to continue to work through issues associated with members not being able to access follow-up care. ACFL has routine meetings with BraveHealth to address any issues as they arise. The relationship with BraveHealth continues to strengthen to meet the needs of the members.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Assessment
HSAG recommended the following: • AmeriHealth-M was unable to sustain the statistically significant improvement in the performance indicator rates achieved during Remeasurement 1 for the Administration of the Transportation Benefit PIP. For unsuccessful interventions, the plan should make data-driven decisions to revise the current intervention or discontinue it and implement new interventions. • The plan should consider using QI science tools such as process mapping, FMEA, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plan should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small-scale using PDSA cycles should be ramped up and adopted planwide in order to impact the entire eligible population.
Response
a. Describe why this weakness exists: • During remeasurement period 2, AmeriHealth Caritas Florida transitioned from Access2Care (1/1/2020-3/31/2020) to Medical Transportation Management (4/1/2020- present) as the Non-emergency Medical Transportation broker. Although during the first three months of remeasurement period 2 ACFL was exceeding the A leg timeliness experienced in remeasurement period 1, it was not sustained for the remainder of the period with MTM. Major factors that contributed to the improvement not being maintained or exceeded were due to PHE pandemic declaration in January 2020 by the Centers for Disease Control and prevention, transition between NEMT brokers from Q1 to Q2, and the need for outreach to Prescribed Pediatric Extended Care facilities. The PHE pandemic declaration in January 2020 by the CDC impacted comparability for Baseline to Remeasurement 2 in a number of ways. Early in 2020, overall utilization and volume decreased as many non-essential (urgent) procedures being postponed and physician offices closing or offices limiting in-person appointments. This continued through our transition from A2C to MTM in April. In May, trip volumes began to increase again as restrictions start to lift and more facilities re-open to in-person visits. Although overall utilization was below normal in 2020, Plan enrollment increased by approximately 30,000 due to impacts of PHE and coverage being extended. As we partnered with MTM it was evident that Prescribed Pediatric Extended Care (PPEC) facility transport requests were identified as a potential driver in the non-compliance. The members who were reported as arriving after their scheduled appointment time were predominantly affiliated with PPEC facilities. It was discovered that the PPEC facilities documented duplicated pickup and appointment arrival times on transportation provider trip logs, thus resulting in reported timeliness non-compliance. Review of MTM's data confirmed the issue was impactful enough to result in non-compliance for A-leg appointment timeliness.
b. Describe initiatives implemented based on recommendations: • Once it was identified that the PPEC reporting did not accurately reflect the on-time expectations and practices of the facilities, initiatives focusing on PPEC outreach and transportation request form education were put into place. MTM deployed their Facility Outreach team to hold routine meetings with PPEC facilities on a bi-monthly basis in 2021. The PPEC facility meetings with MTM continued into 2022 and are now held on a quarterly basis. Education and outreach included: Speaking with PPECs about ensuring the times for arrival reflected when the children needed to be at the facility. Educating centers to notify MTM of changes to scheduled appointments. Discussed ways to better communicate arrival times to parents/guardians. Encouraged facilities to inform MTM when a child

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
was discharged from a PPEC. Best safety practices during the PHE. Ensuring families have the information needed to schedule/change transportation based on the need.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • PPEC facility trips continued to be a top trip request and transportation providers continued to feel the lasting impacts of the PHE on staffing and resources. Targeted interventions have increased the percentage of scheduled leg A trip requests where the member was delivered before or on time for their scheduled appointment. Apart from calendar year 2020 (remeasurement period 2), where we switched NEMT brokers, ACFL has met or exceeded the 90% goal. Although we have not met the 97.1% A leg timeliness metric met in 2019, we have increased the A leg timeliness percentage each remeasurement period for 2021 (92.36%) and 2022 (93.57%).
d. Identify any barriers to implementing initiatives: • Nothing noted at this time.
e. Identify strategy for continued improvement or overcoming identified barriers: • ACFL will continue with PPEC outreach to ensure transportation request forms are completed accurately
HSAG Assessment

Community Care Plan-M

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendation for Access/Availability of Care
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members do not consistently access preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance. If the PHE was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
Response
a. Describe why this weakness exists: • Low performance due to lack of up-to-date contact information, and member perception if healthy, there is not a need to access services.
b. Describe initiatives implemented based on recommendations: • Continue Pay for Performance (P4P) incentives. Community Care Plan (CCP) P4P provider groups receive monthly report cards with performance targets based and member lists to show members that need to be outreached for a visit. In SFY 22/23 P4P groups received an additional report with contact information for members.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Demonstrated 4.82% increase in performance from Q3 2022 to Q4 2022.
d. Identify any barriers to implementing initiatives: • Member perception of accessing services only when sick, Members scheduling appointments then canceling the appointment.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue P4P incentives, monthly report cards and member lists. Telehealth Program with Virtualist practitioner, Robocall Reminders.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Identify best practices for ensuring children receive medically appropriate preventive vaccinations. Consider whether there are disparities within the plan's populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause of children not receiving medically appropriate immunizations, implement appropriate interventions to improve the immunization rates.
Response
a. Describe why this weakness exists: • Low performance was due to Parent/Guardian perception around vaccinations, religious exemptions for school enrollment, there are no disparities between zip codes or age, however there is higher compliance

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
rate with members that identify as Asian although it is not statistically significant due to volume size, and members that identify as Hispanic compared non-Hispanic members.
b. Describe initiatives implemented based on recommendations: • Continue provider P4P incentives for Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA) measures. Monthly report cards and member lists to P4P providers to let them know the members on the panel that are noncompliant with vaccinations. Care Management vaccine reminders and encouragement to discuss vaccine information with pediatrician.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increased Rates for CIS Combo 3 MY2021 (64.72%) to MY2022 (65.21%) and IMA Combo 1 MY2021 (75.67%) to MY2022 (77.62%).
d. Identify any barriers to implementing initiatives: • Parent/Guardian perception around vaccinations, lack of up-to-date contact information for members.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue P4P incentives and reports including most up to date contact information, care management vaccine reminders, and send targeted vaccination reminder messages to members.
HSAG Assessment
Recommendation for Pediatric Care Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to identify barriers to children between 6 and 12 years of age who were diagnosed with ADHD receiving one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication. Upon identification of any root causes contributing to these gaps in care, implement appropriate interventions to improve the use of evidence-based practices related specifically to the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure.
Response
a. Describe why this weakness exists: • Parent/Guardian does not understand condition, appointment scheduled after 30 day follow up timeframe, and although medication is filled parent/guardian may choose to not give member medication.
b. Describe initiatives implemented based on recommendations: • Increased education to parent/guardian to members prescribed ADHD medication, continue ADHD medication management pharmacy internal outreach program.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase rates for Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase from MY2021 (33.97%) to MY2022 (41.94%).
d. Identify any barriers to implementing initiatives: • Parent/Guardian does not understand condition, appointment scheduled after 30 day follow up timeframe, and although medication is filled parent/guardian may choose to not give member medication.
e. Identify strategy for continued improvement or overcoming identified barriers: • Dedicated pharmacy technician for behavioral health medication outreach initiatives, partner with pharmacy benefit manager on engaging and driving member compliance.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG Assessment
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members with diabetes are not receiving eye exams (retinal). Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to receiving eye exams (retinal).
Response
a. Describe why this weakness exists: • Member declines receiving routine eye exam during the PHE, large provider group not screening members with eye vendor in clinic camera, lack of up-to-date contact information for members.
b. Describe initiatives implemented based on recommendations: • At home visits for members with eye exam care gap.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase rates for Eye Exam for Patients with Diabetes from MY2021 (44.04%) to MY2022 (54.74%).
d. Identify any barriers to implementing initiatives: • Member continues to not want to have practitioner come into the home, lack of up-to-date contact information for members.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue at home visits for eye exam compliance. Partner with large provider group to have eye vendor exam days in office/clinic.
HSAG Assessment
Recommendations for Living with Illness Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why members 18 years of age and older who are current smokers or tobacco users did not receive cessation advice during the measurement year. Upon identification of a root cause, implement appropriate interventions and develop measurable, timebound goals specifically focused on evaluating these interventions' impact toward improving the performance related to smoking cessation.
Response
a. Describe why this weakness exists: • Lack of willingness to disclose tobacco use status, lack of compliance with tobacco cessation program.
b. Describe initiatives implemented based on recommendations: • Continue education through Care Management, Tobacco Cessation Healthy Behavior Program, and AHEC Tobacco Free Florida referrals.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Currently aggregating data for implemented initiatives. Performance data will be reviewed for increase in performance during CCP Quality Improvement Committee.
d. Identify any barriers to implementing initiatives: • Member does not follow up after referral to cessation program, member does not report enrollment in tobacco cessation program.
e. Identify strategy for continued improvement or overcoming identified barriers: • Increase tobacco cessation referrals, implement additional resources for tobacco cessation during Health Risk Assessment (HRA) process, increase partnership with AHEC.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why some adolescents and adults with a new episode of AOD dependence were not accessing timely treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure.
Response
a. Describe why this weakness exists: • The following factors impact access to timely treatment: education/understanding of condition, lack of familial/SDOH support, lack of knowledge of how to access care, age.
b. Describe initiatives implemented based on recommendations: • Bed Census monitoring - timely identification - intervention/transition planning at admission (eliminate barriers for transition of care by addressing medical, behavioral and SDOH needs).
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase rates for Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment - Total from MY2021 (36.59%) to MY2022 (37.72%).
d. Identify any barriers to implementing initiatives: • Member noncompliance with treatment plan. Lack of up-to-date contact information for members, and lack of engagement from members.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue motivational interviewing, enhance network to support timely access including specialty provider to support substance use.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Evaluate opportunities to enhance care coordination to support members in accessing timely follow-up care after hospitalization for mental illness. Additionally, the plan should partner with its contracted providers to identify barriers that impede providers from following recommended guidelines for patient monitoring and follow-up after hospitalization for mental illness.
Response
a. Describe why this weakness exists: • The following factors impact access to timely follow up: education/understanding of condition, lack of familial/SDOH support, lack of knowledge of how to access care, age.
b. Describe initiatives implemented based on recommendations: • Maintain collaboration with providers to provide discharge information for timely follow up visit, Follow-Up After Hospitalization for Mental Illness - 7 days Total (FUH 7 Day) measure added to P4P primary care practitioners. FUH 7 Day $25 Healthy Behavior Reward Implemented, P4P partnerships with Behavioral Health providers.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase rates for FUH 7 Day from MY2021 (27.27%) to MY2022 (37.08%).
d. Identify any barriers to implementing initiatives: Member refuses follow up, member schedules and does not show up to appointments, member contacted by multiple entities for follow up, lack of up-to-date contact information.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue motivational interviewing and education to members on condition, maintain collaboration with providers to provide discharge information for timely follow up visit, and enhance network and follow up options for members.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why members who access the ED for AOD abuse or dependence are not accessing or receiving timely follow-up care and establish potential performance improvement strategies and solutions. If the PHE was a factor, HSAG recommends that the plan increase the use of telehealth services. Additionally, enhance communication and collaboration with hospitals to improve the effectiveness of TOCs, discharge planning, and handoffs to community settings for members with BH needs.
Response
a. Describe why this weakness exists: • The following factors impact access to timely follow up: education/understanding of condition, lack of familial/SDOH support, lack of knowledge of how to access care, age.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • Motivational interviewing, maintain collaboration with providers to provide ER event information for timely follow up visit, P4P partnerships with Behavioral Health providers, engage in ongoing collaboration and multidisciplinary team meetings with community partners.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase rates from MY2021 (3.92%) to MY2022 (15.69%).
d. Identify any barriers to implementing initiatives: • Member refuses follow up, member schedules and does not show up to appointments, member contacted by multiple entities for follow up, lack of up-to-date contact information.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue motivational interviewing and education to members on condition, maintain collaboration with providers to provide ER information for timely follow up visit, enhance network to support timely access with specialty providers to support substance use.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis to determine why members 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication did not remain on their antidepressant medications. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Antidepressant Medication Management* measure.
Response
a. Describe why this weakness exists: • Member lack of understanding of condition, member is "feeling better" so does not adhere to medication, member thinks medication is "not working," member fills medication at pharmacy but does not take it.
b. Describe initiatives implemented based on recommendations: • Continue education to members on antidepressant medication management and antidepressant medication management pharmacy internal outreach program.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase Antidepressant Medication Management - Effective Acute Phase Treatment rates from MY2021 (46.24%) to MY2022 (63.81%).
d. Identify any barriers to implementing initiatives: • Member perception of medication, member lack of understanding of condition, member lack of compliance.
e. Identify strategy for continued improvement or overcoming identified barriers: • Dedicated pharmacy technician for behavioral health medication outreach initiatives, partner with pharmacy benefit manager on engaging and driving member compliance.
HSAG Assessment

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why children and adolescents with ongoing antipsychotic medication did not receive metabolic testing during the year. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure.
Response
a. Describe why this weakness exists: • Behavioral health provider not ordering labs for metabolic monitoring, primary care provider not ordering labs for metabolic monitoring. Parent/guardian received lab order but is noncompliant.
b. Describe initiatives implemented based on recommendations: • Motivational interviewing and education to parent/guardian on condition. Care Management facilitates identification of labs not received within the year and assists with appointment scheduling for testing and follow up.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase rate of Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing from MY2021 (28.07%) to MY2022 (50.00%).
d. Identify any barriers to implementing initiatives: • Education to providers on lab ordering for antipsychotics. Parent/guardian received lab order but is noncompliant.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue motivational interviewing, education, and Care Management. Provider reminder of importance of metabolic monitoring. Work closely with labs and providers to explore options regarding at home or in office lab testing.
HSAG Assessment
Recommendations for Behavioral Health Domain
HSAG recommended the following: • Conduct a root cause analysis or focus study to determine why children and adolescents newly started on antipsychotic medications without a clinical indication did not have documentation of psychosocial care as first-line treatment. Upon identification of a root cause, implement appropriate interventions to improve the performance related to the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* measure.
Response
a. Describe why this weakness exists: • Parent/Guardian refusal of first-line psychosocial care, and member does not receive medication if diagnosis is not received at time of fill.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • If diagnosis is not provided to the pharmacy benefit manager at time of fill, medication is not administered.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Increase rates from MY2021 (33.33%) to MY2022 (48.39%).
d. Identify any barriers to implementing initiatives: • Provider not recommending psycho-social care, parent/Guardian refusal of first-line psychosocial care, and new diagnosis not indicated on prescription.
e. Identify strategy for continued improvement or overcoming identified barriers: • Provider education on first-line psychosocial care. Additional education to parent/guardian on use of first-line psychosocial care and access to care.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • Community Care Plan-M had opportunities to improve the evaluation of the effectiveness of interventions for the Improving 7-Day Follow-Up After Hospitalizations for People With Mental Health Conditions and Emergency Department Visits for People With Mental Health Conditions and/or Alcohol and Other Drug Abuse or Dependence PIP. For unsuccessful interventions, the plan should make data-driven decisions to revise the current intervention or discontinue it and implement new interventions. • The plan should consider using QI science tools such as process mapping, FMEA, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plan should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small scale using PDSA cycles should be ramped up and adopted planwide in order to impact the entire eligible population.
Response
a. Describe why this weakness exists: • Low performance due to moving from Behavioral Health managing entity to managing Behavioral Health as part of CCP whole person Concierge Care Coordination (C3) model.
b. Describe initiatives implemented based on recommendations: • Use failure modes and effects analysis (FMEA), continue to test $25 Healthy Behavior Member Incentive for Post Behavioral Health Admission Follow Up Visit, continue adoption of Behavioral Health huddles, and administer behavioral health survey for members.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Indicator 1: 7-day Follow-Up After Hospitalization for Mental Illness (FUH) Increase rate from MY2021(27.27%) to MY 2022 (37.08%) and Indicator 3: 7-day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) Increase rate from MY2021(3.92%) to MY 2022 (15.69%).
d. Identify any barriers to implementing initiatives: • Member lack of awareness of healthy behavior program for Post Behavioral Health Admission Follow Up Visit.
e. Identify strategy for continued improvement or overcoming identified barriers: • Continue to test $25 Healthy Behavior Member Incentive for Post Behavioral Health Admission Follow Up Visit and adoption of Behavioral Health huddles. Discuss Behavioral Health access to care during one of CCP's quarterly Members Matter Committee meetings and implement additional initiatives based on the feedback provided, and administer behavioral health survey for members.
HSAG Assessment

Appendix E.

Long Term Care Plus Plans

Florida Community Care-L

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Recommendations for Methodology
HSAG recommended the following: • In Step 7 (Accurate Data Reporting and Analysis), Florida Community Care-L had an opportunity to improve the narrative interpretation of data and addressing factors that impact the comparability and validity of the reported data. The plans must ensure that the reported data and corresponding analysis in the submitted PIP form are accurate.
Response
a. Describe why this weakness exists: • FCC has exceeded the state goal/target of 90% for three (3) consecutive years on the Transportation PIP. Step 7 was not addressed in the Plan specific feedback in the April 2023 EQR Technical Report.
b. Describe initiatives implemented based on recommendations: • No new initiatives were implemented based on the HSAG recommendations.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
d. Identify any barriers to implementing initiatives: • N/A
e. Identify strategy for continued improvement or overcoming identified barriers: • N/A
HSAG Assessment • Step 7 for Florida Community Care-L was addressed on page 82 of the April 2023 EQR Technical Report. However, it was not included in the plan-specific feedback appendix. HSAG acknowledges this oversight.
Recommendations for Assessment
HSAG recommended the following: • In Step 9 (Assessment of Improvement Achieved) of the PIPs, Florida Community Care-L was unable to achieve any improvement for the Administration of the Transportation Benefit PIP. For unsuccessful interventions, the plan should make data-driven decisions to revise the current intervention or discontinue it and implement new interventions. • The plan should consider using QI science tools such as process mapping, FMEA, or a key driver diagram to identify and prioritize barriers and opportunities for improvement. • The plan should consider seeking enrollee input to better understand enrollee-related barriers toward access to care. • The interventions deemed successful when tested on a small scale using PDSA cycles should be ramped up and adopted planwide in order to impact the entire eligible population.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
Response
a. Describe why this weakness exists: N/A
b. Describe initiatives implemented based on recommendations: • FCC uses the Fishbone Analysis annually to identify barriers for improvement. FCC along with our transportation vendor started with an enrollee satisfaction survey with enrollees' post transportation use. Regular meetings are held to discuss solutions to provide better outcomes. The transportation vendor implemented IVR reminder calls to reduce enrollee no shows.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Enrollee transportation satisfaction has improved quarter over quarter from 79.93% in quarter 1 to 88.80% in quarter 2, as a result of the enrollee satisfaction surveys and regular meetings with the transportation vendor.
d. Identify any barriers to implementing initiatives: • Unable to contact enrollees or Unwilling to complete the survey.
e. Identify strategy for continued improvement or overcoming identified barriers: • Care manager to continually update enrollee contact information and encourage enrollees to be responsive to cooperate with surveys.
HSAG Assessment

Dental Plans

DentaQuest-D

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Annual Dental Visit
HSAG recommended the following: • DentaQuest-D fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator. HSAG recommends that the plan continue to monitor rates over time to identify the PHE's impact on rates, ensuring that lower access to dental care is not driven by a cause other than the PHE, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, HSAG recommends that the dental plan also evaluate its network to ensure enough providers are available to provide services to members.
Response
a. Describe why this weakness exists: • Access to care due to impact of the PHE. The PHE caused an increase in membership, but network size and capacity remained the same (or even shrunk due to providers shutting down or cutting back hours for Medicaid due to low reimbursement that did not account for increased costs of doing business in these inflationary times). DQ saw about the same number of members (numerator) but due to the influx of members due to the PHE the denominator increased.
b. Describe initiatives implemented based on recommendations: • We continue to monitor the impact of the winddown of the PHE and also the impact of inflation on dental offices and practices. We continue to recruit new providers and engage existing providers in order to increase capacity. We opened 5 dental offices in the Panhandle to address access in that area. We are looking at how VBR might impact access and capacity. We reimburse providers for using teledentistry as a means to stimulate access through that modality
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We will not be able to see the results until the PHE winddown is completed as the impact is too early to tell.
d. Identify any barriers to implementing initiatives: • Rates in Florida are some of the worst in the country. Thus providers are not as willing (especially with inflation) to participate in Medicaid or are cutting back on Medicaid
e. Identify strategy for continued improvement or overcoming identified barriers: • Rates are beyond the plans control. Rates are outside the Agency's control as well. Rates are a legislative decision as to increase the pool of funds available for dental
HSAG Assessment • NA—No results available at time of reporting.
Additional Measures
HSAG recommended the following: • The statewide average rates for *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators demonstrated a decline of more than 11 percentage points from MY 2020 to MY 2021. HSAG recommends that the plan conduct a root cause analysis or focus study to determine any barriers to children receiving a dental

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
treatment service to prevent dental caries, which is one of the most common childhood chronic diseases. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve access to care. If access to care is the reason for lower rates, HSAG recommends that the plan also evaluate its network to ensure enough providers are available to provide services to members, and to ensure those providers have appropriate appointment availability.
Response
a. Describe why this weakness exists: • Number of ED visits increased more than 16 times the value reported in 2020 (45 vs 744). Due to the PHE, many ED did not have the capacity to treat members presenting with a primary issue of non-traumatic dental. In addition to limited ED access, people were fearful to seek care through an Emergency Department due to the risk of the PHE exposure. The increase in non-traumatic dental visits requiring follow up in the year following was competing for limited access and provider availability due to COVID restrictions, the staffing impact of the PHE and the increased membership from the PHE.
b. Describe initiatives implemented based on recommendations: • We continue to recruit new providers and engage existing providers in order to increase capacity. We opened five (5) dental offices in the Panhandle to address access in that area. We are looking at how VBR might impact access and capacity. We reimburse providers for using teledentistry as a means to stimulate access through that modality.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Measure calculations changed for last reporting period (MY22) due to data requirements so unable to evaluate change between measurement periods.
d. Identify any barriers to implementing initiatives: • Providers are not as willing (especially with inflation) to participate in Medicaid or are cutting back on Medicaid due to low rates.
e. Identify strategy for continued improvement or overcoming identified barriers: • We will continue recruitment and engage existing providers. Continue efforts to re-educate members on seeking care from dentist or teledentistry for non-traumatic dental and not the Emergency department.
HSAG Assessment
• NA—No results available at time of reporting.

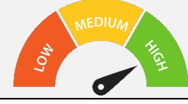
2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • For the Coordination of Transportation Services With the SMMC Plans PIP, DentaQuest-D reported finalized Remeasurement 1 (CY 2020) rates for the PIP performance indicator(s). DentaQuest-D did not report any improvement in PIP outcomes. HSAG recommends that the plan complete the PDSA cycle, test interventions, evaluate the effectiveness of the interventions, and implement new interventions to ensure statistically significant improvement in the PIP outcomes.
Response
a. Describe why this weakness exists: • The PHE pandemic, which stared in early 2020, resulted in a stay-at-home order and the suspension of all elective medical procedures, including dental services, for approximately two months. Once non-emergency medical and dental services were reinstated, most dental offices across the state reopened with limited capacity, insufficient staffing, and additional practice restrictions related to social distancing and PPE. These external factors undermine the validity of any comparisons between the Baseline and Remeasurement 1, as we observed a significant decrease in the number of transportation inquiries on NEMT from CY 2019 to CY 2020. Additionally, we discovered the need for more training for call center staff to correctly classify and document transportation inquires.
b. Describe initiatives implemented based on recommendations: • DQ began holding bi-weekly interdepartmental meetings to identify, implement, and monitor PDSA interventions. Through this process, the interdepartmental group was able to identify a that additional training and support was needed to correctly classify transportation calls and to properly document information given to DQ members related to NEMT. DQ Customer Service training team was tasked with conducting additional training with FL call center staff to ensure proper classification of transportation inquiries and accurate and thorough documentation of their efforts to educate members on NEMT and direct them to their health plan vendor for further assistance. Addressing the training and documentation gaps also resulted in increased accuracy when calculating the denominator and numerator for this PIP.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • New training guidelines for transportation calls were implemented with all existing FL call center staff, as well as with all 391 call center agents hired during CY 2020. We identified 14 calls that had been erroneously classified as transportation inquiries, which improved the validity of the denominator for Remeasurement 1.
d. Identify any barriers to implementing initiatives: • Correct classification and documentation of transportation inquiries is dependent on call center staff performance and adherence to training guidelines. As such, this is still a manual data entry system and error can be reduced, but not eliminated.
e. Identify strategy for continued improvement or overcoming identified barriers: • DQ will adopt this improvement strategy as all customer service agents have completed the training on how to classify calls from members. Quality team will continue to review transportation inquiry reports from customer service monthly to assess data accuracy and monitor the effectiveness of call center staff training.
HSAG Assessment

Liberty-D

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Annual Dental Visit
HSAG recommended the following: • Liberty-D fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator. HSAG recommends that the plan continue to monitor rates over time to identify the PHE's impact on rates, ensuring that lower access to dental care is not driven by a cause other than the PHE, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, HSAG recommends that the dental plan also evaluate its network to ensure enough providers are available to provide services to members.
Response
a. Describe why this weakness exists: • LIBERTY believes the decrease related to the Annual Dental Visits – Total (ADV) rate is largely attributable to the unprecedented challenges posed by the PHE pandemic. During the pandemic, dental offices experienced closures and restrictions, which significantly impacted access to dental care for our members. The disruptions in service availability, the need for enhanced safety protocols, and the understandable hesitancy of individuals to seek routine dental care during the pandemic all contributed to a decrease in the utilization of dental services. As a result, we have observed lower rates of annual dental visits than originally anticipated.
b. Describe initiatives implemented based on recommendations: • LIBERTY has launched initiatives that directly and indirectly benefit the ADV rates. Examples include: pay for performance provider incentive programs; text message outreach campaigns to encourage utilization; telephonic outreach to encourage utilization; a dedicated community outreach unit that conducts in-person outreach, provides dental benefits and dental health education, and provides dental screenings (by the appropriately licensed/certified staff); and our Healthy Behaviors Program that informs enrollees of the importance of dental health by incentivizing them to practice healthy dental habits, such as practicing good oral hygiene and utilizing their dental benefits.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • When comparing Annual Dental Visit – Total (ADV) rates between SFY 2020-2021 (38.99%) to SFY 2021-2022 (43.48%), LIBERTY reports an 11.52% increase with this rate.
d. Identify any barriers to implementing initiatives: • Financial Barriers: Socioeconomic factors, and families with limited financial resources can prevent families from seeking dental services for their children. Fear of losing a job, cost of transportation, and food insecurities are contributing factors in prioritizing dental care and the ability to earn a living and maintain basic needs. The economic impact of the pandemic has augmented the financial strain for many families, leading to job losses and reduced income. • Telehealth limitations: Telehealth options for dental consultations and assessments are instrumental in emergency room diversion and placing children with the right provider, dental care is primarily hands-on and often requires in-person visits. • Knowledge and Awareness Barriers: Parents or caregivers may not be fully aware of the importance of early dental care or the availability of pediatric dental services. Lack of knowledge about oral health, preventive measures, and the significance of regular dental visits can contribute to children not receiving necessary treatment. • Cultural Barriers: Cultural beliefs or practices related to oral health may also influence the utilization of dental services.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• Geographic Barriers: Children living in rural or remote areas may face challenges in accessing dental care due to the limited availability of dental providers or long travel distances to reach dental clinics. • Disruption of school-based programs: School-based dental programs, such as sealant programs and oral health education initiatives, were disrupted due to staffing shortages. These programs often play a crucial role in providing preventive dental care for children, especially those from low-income families. • Access to dental clinics: Many dental clinics have reduced their services post-pandemic due to staffing shortages, financial constraints, and inflation of cost of supplies. • Fear and Anxiety: Dental anxiety or fear can be a barrier, particularly for young children. Parental fear of dental procedures, pain, or negative past experiences can deter their parents from seeking dental treatment. • Systemic Barriers: Administrative barriers in provider enrollment in the Medicaid program can hinder access to dental treatment for children. Complex processes and administrative hurdles can discourage providers from administrating care to children enrolled in Medicaid programs.
e. Identify strategy for continued improvement or overcoming identified barriers: • LIBERTY will continue to monitor the ADV rates and continue to implement quality improvement (QI) strategies that will support continued increase of this rate. Additionally, we will work diligently to evaluate our provider network to ensure that an adequate number of dental care providers are available to meet the needs of our members. We understand the importance of maintaining access to quality dental care for our members and are committed to making the necessary adjustments to improve our performance in these challenging times. As the situation evolves, we will remain vigilant in our efforts to provide the best possible dental care services to our members.
HSAG Assessment
Additional Measures
HSAG recommended the following: • The statewide average rates for *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators demonstrated a decline of more than 11 percentage points from MY 2020 to MY 2021. HSAG recommends that the plan conduct a root cause analysis or focus study to determine any barriers that prevent children from receiving a dental treatment service to prevent dental caries, which is one of the most common childhood chronic diseases. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve access to care. If access to care is the reason for lower rates, HSAG recommends that the plan also evaluate its network to ensure enough providers are available to provide services to members, and to ensure those providers have appropriate appointment availability.
Response
a. Describe why this weakness exists: • LIBERTY believes the PHE pandemic was the main cause of this rate's increase. During the pandemic, dental offices closed, and some never re-opened even after lockdown restrictions began being lifted. Due to the office closure and restrictions on health and dental care, members sought the emergency department for their primary care which also correlated with 50 new freestanding emergency departments from Orlando Health and Advent to Florida Health Information Exchange (HIE).

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
b. Describe initiatives implemented based on recommendations: • Since MY 2020 and MY 2021, LIBERTY continued to expand and devote more resources to its Case Management (CM) Department as well as continued to engage the population from previously developed outreach methods. Additionally, various process improvements occurred during the look-back period within our Case Management triage and risk stratification work plan that now included transportation events, medical record events, community smiles (social determinants of health) dental record events, nursing care plan events, unable to contact events, and CM DMTR events to all be captured. These enhancements not only allowed for staff to document more concisely based on CM obligations but to better audit our member's records for internal and external resources. The Case Management Department also increased its growth, doubling the case manager staff and care coordinator staff from the previous year. This growth and process improvement allowed for the creation of three new positions: Director of Case Management, Lead Case Manager, and Lead Care Coordinator position. Additionally, LIBERTY's Care Management began collaborating with stakeholders to ensure members receive appropriate preventive care for our special needs population. Below are examples of new and current actions devoted to servicing our general and special needs populations: • Audits of Case Manager's and Coordinator's documentation • Follow-up calls to members • Follow-up calls to providers-obtain feedback • Annual Case Management Program evaluation • Annual QMI program evaluation in Florida • Review of utilization data-claims • Review of utilization data for OHRA and enrollment in Case Management • Quarterly SPCAC meetings
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • When comparing Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total and 30-Day Follow-Up—Total rates between SFY 2020-2021 (7-Day: 32.84%, 30-Day: 50.00%) to SFY 2021-2022 (7-Day: 27.87%, 30-Day: 42.21%), LIBERTY reports a 15.13% decrease in ED rates for 7-Day Follow-Up and a 15.58% decrease in ED rates for 30-Day Follow-Up.
d. Identify any barriers to implementing initiatives: • The PHE pandemic poses the barriers mentioned in response (a), however, LIBERTY notes that there are many after-effects of the pandemic such as enrollees being more apprehensive to leave their homes and attend dental appointments. This could result in dental-related diagnoses not being made and treated, which would result in increased health-related issues which may require an emergency department visit.
e. Identify strategy for continued improvement or overcoming identified barriers: • LIBERTY will continue to monitor the measures related to emergency department visits measures. As mentioned, LIBERTY has observed a decrease since the MY 2020 and MY 2021, however, improvements are still planned for our Case Management department. Continuous improvement is crucial in providing quality healthcare and LIBERTY practices this by conducting routine evaluations, running a current performance improvement project related to emergency department visits, and development a new enhanced Case Management program as of September 2022. LIBERTY believes that these practices will all support the continued decrease of the ED-related performance measure rates.
HSAG Assessment

2. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • Liberty-D was evaluated for the Design, Implementation, and Outcomes stages (Steps 1 through 9) of the PIP. Liberty-D had an opportunity to improve the process for evaluation of the effectiveness of interventions. HSAG recommends that Liberty-D complete the PDSA cycle and identify processes to improve the evaluation of the effectiveness of the interventions and implement new interventions, as appropriate and based on outcomes.
Response
a. Describe why this weakness exists: • LIBERTY routinely conducts and documents PDSA cycles for all our validated and non-validated quality and performance improvement projects along with their supporting interventions. On LIBERTY's previous submission, PDSA cycles were conducted for all three submissions, however LIBERTY was unaware that the final submission required the supplemental documentation.
b. Describe initiatives implemented based on recommendations: • LIBERTY routinely conducts and documents PDSA cycles for all our validated and non-validated quality and performance improvement projects along with their supporting interventions and will submit all required and supplemental documentation going forward.
c. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • PDSA cycles have proven to be successful in identifying root cause issues with quality and performance improvement interventions if they are not producing the expected result.
d. Identify any barriers to implementing initiatives: • None to report.
e. Identify strategy for continued improvement or overcoming identified barriers: • LIBERTY will continue to conduct and document PDSA cycles for validated and non-validated quality and performance improvement projects along with their supporting interventions.
HSAG Assessment 

MCNA-D

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Annual Dental Visit
HSAG recommended the following: • MCNA-D fell below the plan-specific targets identified by the Agency for the *Annual Dental Visit—Total* measure indicator. HSAG recommends that the plan continue to monitor rates over time to identify the PHE's impact on rates, ensuring that lower access to dental care is not driven by a cause other than the PHE, and adopt QI strategies to improve rates. If access to care is the reason for lower rates, HSAG recommends that the dental plan also evaluate its network to ensure enough providers are available to provide services to members.
Response
a. Describe why this weakness exists: • Access to care is the reason for lower rates. Given access to care has resulted in lower rates, the weakness identified in the viability of care being accessed was in fact the weakness itself. This weakness persisted during a time in which care accessibility was not elevated through the interventions in play.
b. Describe initiatives implemented based on recommendations: • The plan evaluated its network to ensure enough providers are available to provide services to members. Additionally, the interventions in play needed to be evaluated and optimized. Strategic call campaigns stratifying various modes of telecommunication coupled with an innovative risk identification formula will inform targeted outreach as a promising solution.
c. Identify any noted performance improvement because of initiatives implemented (if applicable): • Any note to performance improvement is not applicable. Not applicable in that best practices dictate one will have a substantive sign of improvement (or lack of improvement) within 27 months or five PDSA cycles to test for improvement.
d. Identify any barriers to implementing initiatives: • There are no barriers identified to implementing initiatives.
e. Identify strategy for continued improvement or overcoming identified barriers: • Strict monitoring of access to care is critical to avoid the weaknesses identified above. This strategic insight must and shall remain critically resolved.
HSAG Assessment
• NA—No results available at time of reporting.
Additional Measures
HSAG recommended the following: • The statewide average rates for *Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators demonstrated a decline of more than 11 percentage points from MY 2020 to MY 2021. HSAG recommends that the plan conduct a root cause analysis or focus study to determine any barriers that prevent children from receiving a dental treatment service to prevent dental caries, which is one of the most common childhood chronic diseases. Upon identification of a root cause, HSAG recommends that the plan implement appropriate interventions to improve access to care. If access to care is the reason for lower rates, HSAG recommends that the plan also evaluate its network to ensure enough providers are available to provide services to members, and to ensure those providers have appropriate appointment availability.

1. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Response
a. Describe why this weakness exists: • The proliferation of hospitals participating in the Event Notification System (ENS) network expanded and matured throughout the mid-point of MY 2020 and 3rd quarter of MY 2021. Audacious Inquiry (the ENS vendor), over time, optimized its processes to capture more enrollees in their identification / plan-affiliation heuristics. The Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total and 30-Day Follow-Up—Total measure's denominator(s) is informed by the volume of enrollees communicated to the plan through the ENS. Throughout the measurement periods discussed, the changes in volume resulted in intervention-fatigue in that the resources required for interventions were not actively accommodating the demand placed on them. Increases in emergency room discharges; increases beyond well-established trends; trends used to inform the intervention design. The resources allocated toward the interventions were not scaled. The supply of resources needed to meet demand, thereby ensuring proper expectations of intervention efficacy, was the weakness addressed upon Root Cause Analysis.
b. Describe initiatives implemented based on recommendations: • Additional Member Advocate Outreach Specialists (Licensed Dental Hygienists) were onboarded to support in the execution of interventions designed for the Follow-Up After ED Visits for Dental Caries in Children—7-Day Follow-Up—Total and 30-Day Follow-Up—Total measure. The root cause analysis revealed the need to bring equilibrium between supply and demand or intervention resources and enrollee volume, respectively.
c. Identify any noted performance improvement because of initiatives implemented (if applicable): • At this point in time, any note to performance improvement is not applicable. Not applicable in that best practices for testing improvement dictate one will have a substantive sign of improvement (or lack of improvement) within 27 months or nine PDSA cycles.
d. Identify any barriers to implementing initiatives: • There are no barriers to report.
e. Identify strategy for continued improvement or overcoming identified barriers: • The strategy, in view of the weakness identified above, is based on ensuring the supply of resources required of interventions is actively monitored so said interventions are effectively executed while allowing the plan to implement appropriate interventions to improve access to care.
HSAG Assessment
• NA—No results available at time of reporting.

Appendix F. EQR Technical Report Requirements

Table F-1 lists the required and recommended elements for the EQR technical report, in accordance with 42 CFR §438.364 and recent CMS technical report feedback received by states. Table F-1 identifies the page number where the corresponding information that addresses each element is located in the EQR technical report.

Table F-1—EQR Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR technical report by April 30.	Cover Page
2	All eligible Medicaid and CHIP plans are included in the report.	Pages 2 – 5 Appendix A
3	Required elements are included in the report:	
3a	Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity.	Page 7 – 8
3b	An assessment of the **strengths and weaknesses of each MCO, PIHP, PAHP and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the healthcare services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified weaknesses.	Appendix C
3c	Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid and/or CHIP enrollees.	Pages 12 – 14
3d	Recommends improvements to the quality of healthcare services furnished by each MCO.	Appendix C
3e	Provides state-level recommendations for performance improvement.	Pages 11-14, 54 – 55, 81 – 87
3f	Ensures methodologically appropriate, comparative information about all MCOs.	Pages 9 – 11, 31 – 32, 40, 44, 50, 54 – 55, 66 – 75, 78, 80 – 87, 97 – 101, 102 – 111, 115 – 122, 125 – 126, Appendix D
3g	Assesses the degree to which each MCO has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR.	Appendix E

	Required Elements	Page Number
4	**Validation of PIPs:** A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
4a	**Interventions.**	Pages 106 – 111, 113, 119 –120
4b	Objectives.	Page 88 Appendix B
4c	Technical methods of data collection and analysis.	Pages 88, 91, 94 Appendix B
4d	Description of data obtained.	Page 95 Appendix B
4e	Conclusions drawn from the data.	Pages 121 – 122
5	**Validation of performance measures**: A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	
5a	Objectives.	Page 56 Appendix B
5b	Technical methods of data collection and analysis.	Appendix B
5c	Description of data obtained.	Page 56 Appendix B
5d	Conclusions drawn from the data.	Pages 59 – 65, 81 – 87
6	**Review for compliance:** 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report include information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	
6a	Objectives.	Page 26 Appendix B
6b	Technical methods of data collection and analysis.	Pages 27 – 30, Appendix B
6c	Description of data obtained.	Appendix B
6d	Conclusions drawn from the data.	Pages 54 – 55

	Required Elements	Page Number
7	**Encounter Data Validation: Each remaining activity** included in the technical report must include a **description of the activity** and the following information:	
7a	Objectives.	Page 123
7b	Technical methods of data collection and analysis.	Pages 123 – 125
7c	Description of data obtained.	Page 124 – 125
7d	Conclusions drawn from the data.	Page 125 – 126