Florida Agency for Health Care Administration

SFY 2017–2018 External Quality Review Technical Report

May 2019

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Glossary of Acronyms

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

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

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

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

1. Executive Summary

Overview of the External Quality Review

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

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

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

Summary of Findings, Conclusions, and Recommendations

Performance Improvement Projects (PIPs)

During SFY 2017–2018, the MMA plans submitted four PIPs for validation, including the following topics: two state-mandated topics, one additional nonclinical topic, and one additional clinical topic. For the additional clinical topic, the MMA plans were required to select a topic falling into one of three

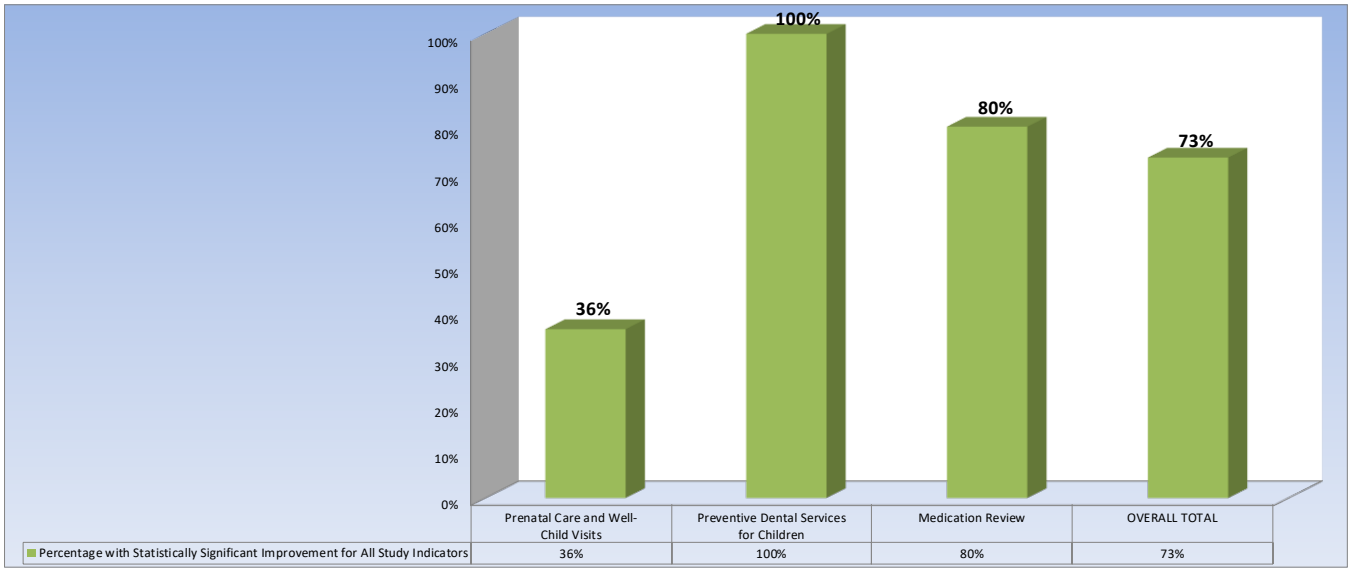
[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register* Vol. 81, No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27886. 42 CFR Parts 364 Medicaid Program; External Quality Review, Final Rule.

categories: a population health issue within a specific geographic area identified as in need of improvement (such as diabetes, hypertension, or asthma); integration of primary care and behavioral health; or reduction of preventable readmissions. The LTC plans submitted two PIPs for validation, including the following topics: one state-mandated topic and one nonclinical topic. Comprehensive plans that offered services for both the MMA and LTC programs submitted six PIPs for validation, adhering to the PIP topic requirements for both programs. For some of the specialty plans, exceptions were made to the mandated PIP topics when the topic did not apply to the population served.

Statistically Significant Improvement

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

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



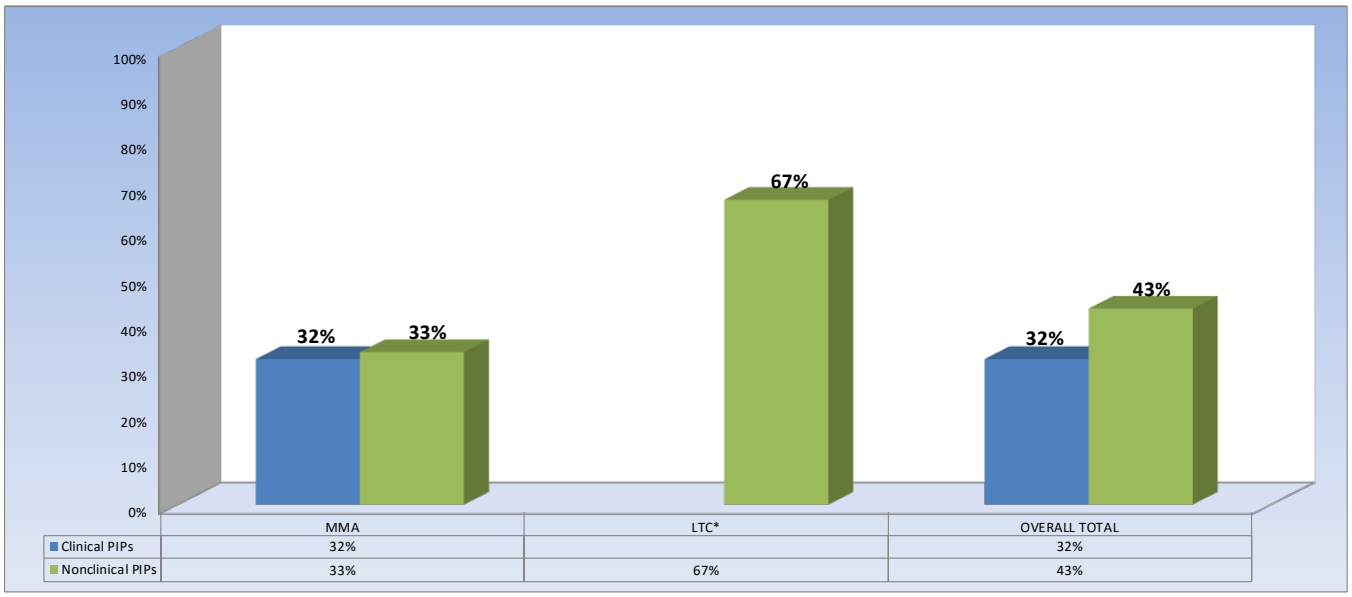
Across the three state-mandated topics, 73 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. The percentage of PIPs demonstrating statistically significant improvement across all study indicators varied by state-mandated topic: 36 percent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

For this year's validation, PIPs that demonstrated statistically significant improvement across all study indicators last year at Remeasurement 1 and had comparable Remeasurement 2 results reported for this year's validation were assessed for sustained improvement in study indicator outcomes. Among the state-mandated PIPs, HSAG evaluated 17 PIPs (three *Improving Timeliness of Prenatal Care and Well-Child*

Visits in the First 15 Months of Life—Six or More Visits PIPs and all 14 *Preventive Dental Services for Children* PIPs) for sustained improvement, and all 17 PIPs were successful in maintaining the significant improvement over baseline across all study indicators for a second re-measurement.

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

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



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

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

For this year's validation, HSAG also assessed for sustained improvement those plan-selected PIPs that demonstrated statistically significant improvement across all study indicators at Remeasurement 1 and had comparable Remeasurement 2 results reported this year. A pattern like the state-mandated PIPs was seen for the nonclinical plan-selected PIPs in that all four PIPs evaluated for sustained improvement successfully maintained significant improvement across all study indicators for the second

remeasurement. The plan-selected clinical PIPs were the only PIPs that did not have a 100 percent success rate in sustained improvement for this year's validation; only one of four clinical PIPs evaluated for sustained improvement was successful at maintaining statistically significant improvement for a second remeasurement period.

Innovative Interventions Associated With Statistically Significant Improvement

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

Overall PIP Validation Status

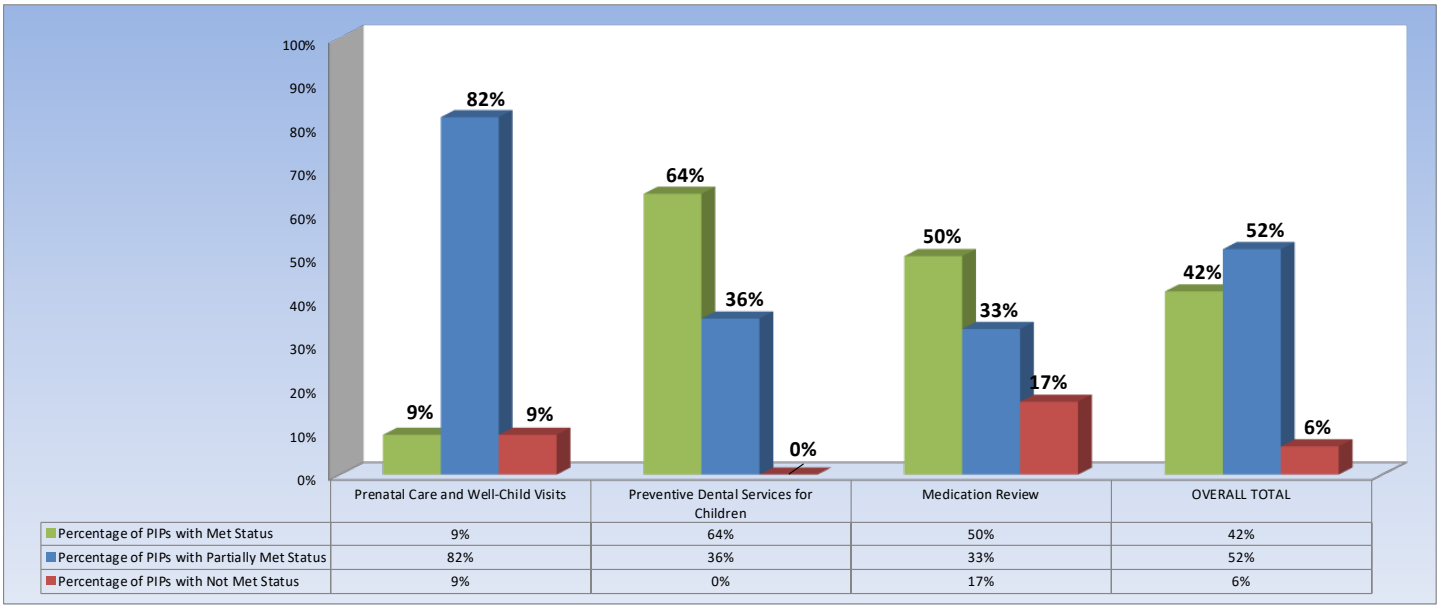
HSAG validated PIPs submitted by all plans as required by the EQRO contract. The outcome of the validation process was an overall validation status finding for each PIP of *Met*, *Partially Met*, or *Not Met*. To determine the overall validation status for each PIP, HSAG evaluated the PIP on a set of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

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

[1-2] Ibid.

with a *Partially Met* validation status, and the red bars represent the percentage of PIPs with a *Not Met* validation status.

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

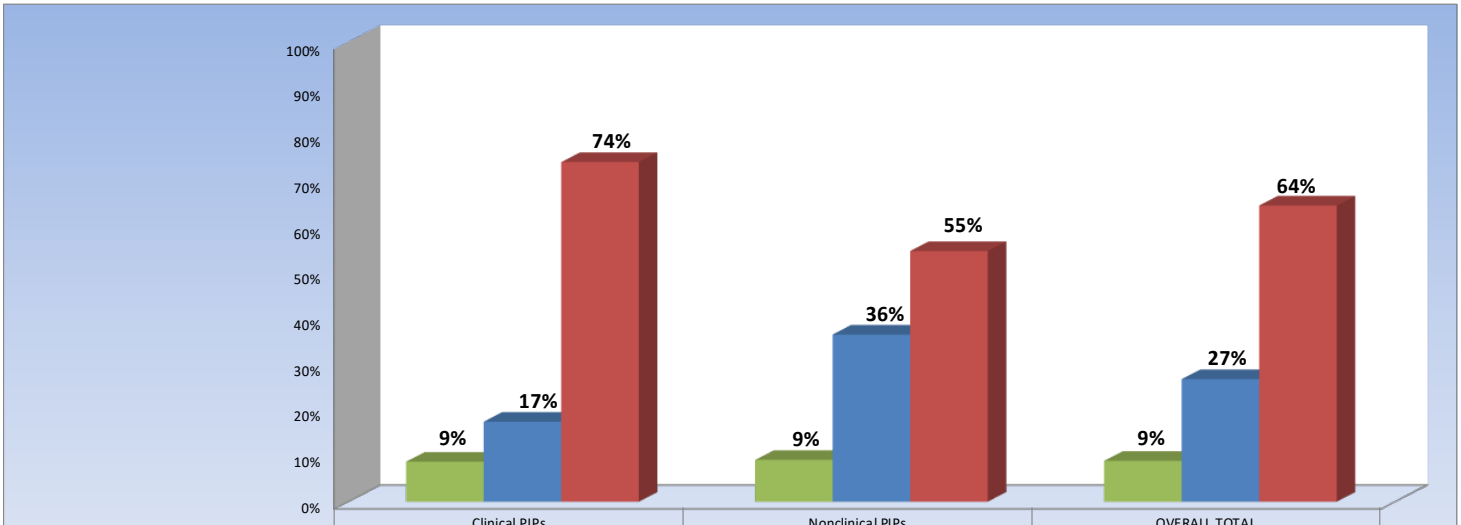


	Prenatal Care and Well-Child Visits	Preventive Dental Services for Children	Medication Review	OVERALL TOTAL
Percentage of PIPs with Met Status	9%	64%	50%	42%
Percentage of PIPs with Partially Met Status	82%	36%	33%	52%
Percentage of PIPs with Not Met Status	9%	0%	17%	6%

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

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

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



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

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

Recommendations

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

Overall recommendations:

- AHCA should continue to explore and identify innovative interventions and share intervention examples with the plans. Sharing potentially promising strategies with the plans may help facilitate improvement in individual PIPs and in statewide efforts.
- The plans should conduct accurate data analyses of study indicator results and appropriate statistical testing between each study indicator re-measurement rate and the baseline rate to evaluate PIP progress toward achieving and sustaining statistically significant improvement in study indicator outcomes.

- The plans should use active, innovative improvement strategies that have the potential to directly and positively impact study indicator outcomes for each PIP.
- The plans should have a methodologically robust process in place for evaluating the effectiveness of each intervention and its impact on the study indicators and should use intervention-specific evaluation results to guide next steps of each intervention.

Performance Measure Validation

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

MMA Plans

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

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

A total of 24 MMA Standard plan performance measure indicators related to **access** were evaluated as part of the Pediatric Care, Women's Care, Behavioral Health, and Access/Availability of Care domains. Of the measures that had an established performance target, two of 15 (13.3 percent) measure indicators met or exceeded the AHCA performance targets. **Additionally, the statewide average met or exceeded the minimum performance targets for seven of 15 (46.7 percent) measure indicators.**

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

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

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

LTC Plans

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

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

Recommendations

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

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

Choice Form and *Plan of* Care—*LTC Service Authorizations*, HSAG recommends that LTC plans ensure proper documentation is maintained for enrollees. For *Case Manager Training*, LTC plans should ensure proper and timely training of their case managers regarding the mandate to report abuse, neglect, and exploitation.

Review of Compliance

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

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

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

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

AHCA also began strategic planning for how to conduct a comprehensive three-year compliance review according to the federal standards. As a part of planning, AHCA requested a cost estimate from its EQRO, to complete the following tasks related to compliance reviews: (1) development of a compliance review tool to include federal and state contract standards, (2) desk reviews of the evidence of compliance provided by the plans, (3) on-site visits to the plans, including interviews with staff and document review, (4) generating preliminary reports of the results of the compliance review using the compliance review tool, and (5) developing full reports of the results of the compliance review in a report format. AHCA has notified the EQRO that the state is working internally to determine how the EQRO can support the state in planning and executing the mandatory three-year compliance review.

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

Recommendations

HSAG recommends the following:

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

2. Introduction to the Annual Technical Report

Purpose Statement

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

Quality, Access, and Timeliness

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

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

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

3. Overview of the Florida Medicaid Managed Care Program

Florida's Medicaid Managed Care Program

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

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

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

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

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

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

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

Florida Medicaid Managed Care Demographics

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

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

The State's Comprehensive Quality Strategy

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

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

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

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

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

1. Priority: Improved health outcomes
   Goal: Focus on priority populations with needed, improved services

2. Priority: Simplified and streamlined service delivery to promote efficient, timely, appropriate use of health services
   Goal: Reduce unnecessary emergency department (ED) visits, unplanned pregnancies, Cesarean (C)-sections, hospital readmissions, inappropriate use of medications, etc., through prevention, planning, and service accessibility

3. Priority: Support for person and family-centered care
   Goal: Improve health literacy to engage recipients, families, [and] consumers in healthcare planning and service delivery

4. Priority: Greater transparency and accountability to promote cost effectiveness and efficient administration
   Goal: Promote a quality-focused, data-informed and continuous learning Agency

5. Priority: Improved care coordination via performance monitoring and communication
   Goal: Promote clear communication among providers, plans, patients, families; promote care that is accessible, coordinated, co-located, [and] optimal

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

4. Review of Compliance

Background

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

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

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

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

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

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

Methodology/Technical Methods of Data Collection and Analysis

The following bureaus and offices within AHCA's Division of Medicaid use various methods of review to collect data and monitor plan operations to ensure compliance with all State contract requirements and most of the federally required standards. Listed with each entity is the methodology it used for conducting monitoring and reviews.

Methods of Review by Bureau/Office

Bureau of Plan Management Operations (PMO)

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

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

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

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

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

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

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

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

The Provider Network Oversight Unit (PNOU) is housed within PMO's Standard Plan Management section. PNOU is responsible for the review, monitoring, and maintenance of AHCA-established standards and requirements for provider networks. PNOU also initiates compliance actions against managed care plans who fail to meet the provider network provisions of the contract. PNOU addresses contractually required Access, and Structure and Operations standards through:

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

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

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

The Ft. Lauderdale Field Based Plan Management Unit is responsible for working with managed care plans statewide to address claims management and general plan management issues. This involves reviewing administrative policies, procedures, guidelines, and related directives impacting managed care

plan contract compliance; evaluating contract compliance through oversight of managed care plan claim and claim complaint processing; conducting in-depth reviews, analysis, and trending to identify compliance issues/potential program operations problems; and recommending appropriate action.

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

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

Bureau of Medicaid Quality

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

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

HIPAA Compliance Office

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

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

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

Review of Compliance Actions

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

Corrective Actions

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

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

Plan-Specific Results

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

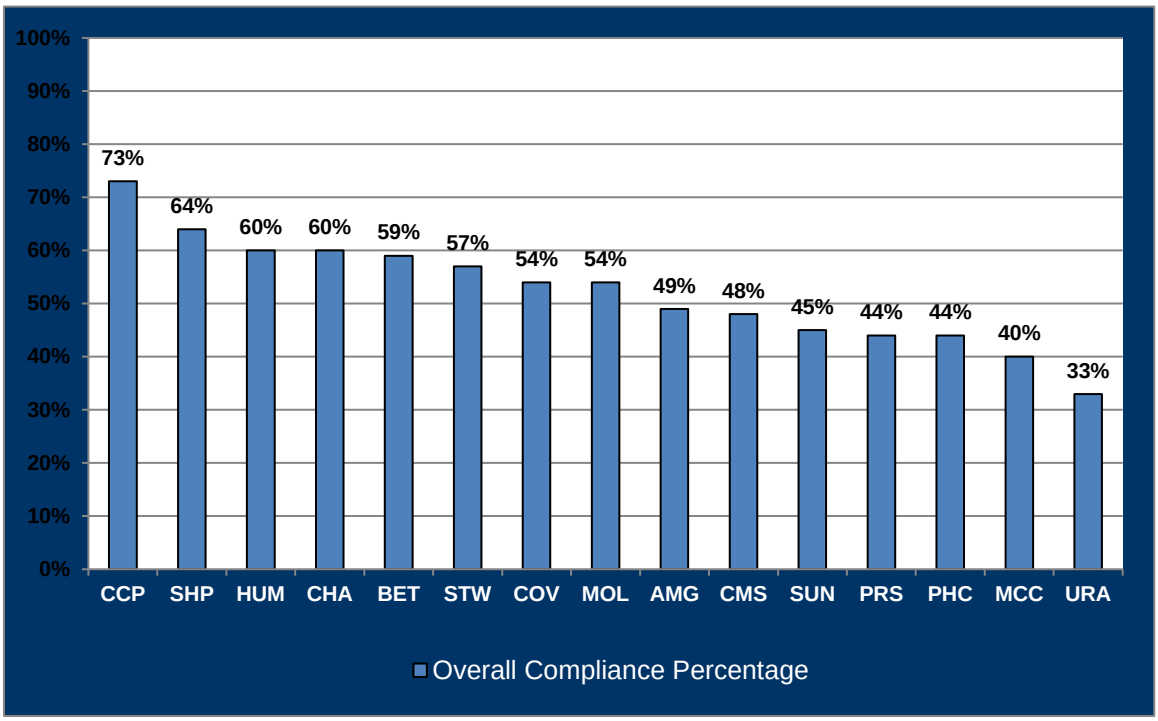
AHCA performed ongoing monitoring of contract requirements, measuring each plan's compliance with specific requirements and standards designed to ensure quality care for pregnant women and their newborns (e.g., prenatal and postpartum care, coordination with Healthy Start programs, referral to community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

- Review of complaints, grievances and fair hearing requests to determine the areas of focus for targeted monitoring.
- Review of medical files of plans' providers for enrollees and their infants to monitor service provision.

- Review of plans' policies and procedures related to prenatal, postpartum, and newborn care to ensure compliance with contract requirements.
- Review of compliance actions related to plans' performance.

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

Figure 4-1—Overall Compliance Percentage by Plan



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

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

In addition to the plan-specific targeted monitoring described above, AHCA engaged in a number of other plan-specific monitoring activities throughout the year that identified areas of non-compliance and

resulted in liquidated damages and/or sanctions. Table 4-1 includes the final actions for the SMMC plans by issue type that AHCA performed during SFY 2017–2018, including an aggregation of all compliance actions, LDs, and sanctions assigned by AHCA per plan.

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

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

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

Recommendations

HSAG established that in accordance with 42 CFR §438.66 State monitoring requirements, AHCA conducted compliance and monitoring activities throughout SFY 2016–2017. AHCA has a comprehensive system that monitors all contract requirements and most of the federal standards for the plans.

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

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

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

HSAG recommends the following for the plans:

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

5. Performance Measures

Objectives

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

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

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

Methodology/Technical Methods of Data Collection and Analysis

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

MMA Plans

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

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

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

PMV Step	Associated Activities Performed by HSAG
MRRV	HSAG examined whether or not the LOs performed a re-review of a random sample of medical records based on NCQA MRRV protocol to ensure the reliability and validity of the data collected.
Health Plan Quality Indicator Data File Review	The MMA plans are required to submit a health plan quality indicator data file for the submission of audited rates to AHCA. The file should comply with the AHCA-specified reporting format and contain the denominator, numerator, and reported rate for each performance measure. HSAG evaluated whether there was any documentation in the FAR to show that the LOs performed a review of the health plan quality indicator data file.

LTC Plans

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

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

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

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

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

Plan-Specific Results

MMA/Specialty Plans

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

Results by Domain

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

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

Results—Pediatric Care

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

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

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

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

** Indicates that lower rates are better for this measure.*
— indicates that the RY 2017 rate is not presented because the MMA plans were not required to report the measure until RY 2018. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2017 rate is not displayed.
[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.
[2] Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between RY 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks were not performed for this measure.
[3] AHCA did not set a performance target for this measure for 2018; therefore, comparisons to benchmarks were not performed for this measure.

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

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

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

Three of 12 (25.0 percent) statewide average rates within the Pediatric Care domain met or exceeded AHCA's RY 2018 performance targets (*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*). Additionally, three measure rates (*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* , *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, and *Adolescent Well-Care Visits*) had rate increases of more than 4 percentage points from RY 2017 to RY 2018. Conversely, four of 12 (33.3 percent) statewide rates (*Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*, *Lead Screening in Children*, *Immunizations for Adolescents—Combination 1*, and *Annual Dental Visit—Total*) fell below the minimum performance target, indicating opportunities for improvement.

Results—Women's Care

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

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

Measure	Measure Source	RY 2017	RY 2018
Women's Care			
Cervical Cancer Screening			
Cervical Cancer Screening	HEDIS	56.08%	59.84%
Chlamydia Screening in Women			
Total	HEDIS	62.55%	64.31%
Breast Cancer Screening[1]			
Breast Cancer Screening	HEDIS	—	58.17%
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	HEDIS	84.26%	81.93%
Postpartum Care	HEDIS	63.55%	64.54%
Contraceptive Care—Postpartum Women			
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	Medicaid Child Core Set	—	1.00%
Ages 15–20 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	Medicaid Child Core Set	—	35.57%
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery	Medicaid Child Core Set	—	0.03%
Ages 15–20 Years, Who Were Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery	Medicaid Child Core Set	—	7.40%
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 3 Days of Delivery	Medicaid Adult Core Set	—	10.83%
Ages 21–44 Years, Who Were Provided Most Effective or Moderately Effective FDA-Approved Methods of Contraception Within 60 Days of Delivery	Medicaid Adult Core Set	—	39.41%

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

[1]Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between RY 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks were not performed for this measure.
— indicates that the RY 2017 rate is not presented because the MMA plans were not required to report the measure until RY 2018. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2017 rate is not displayed.

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

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

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

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

Results—Living With Illness

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

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

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

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

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

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

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

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

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

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

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

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

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

Results—Behavioral Health

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

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

Measure	Measure Source	RY 2017	RY 2018
Behavioral Health			
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]			
Initiation of AOD Treatment—Total—Total	HEDIS	—	41.80%
Engagement of AOD Treatment—Total—Total	HEDIS	—	6.90%
Follow-Up After Hospitalization for Mental Illness[1]			
7-Day Follow-Up	HEDIS & AHCA-Defined	—	30.52%
30-Day Follow-Up	HEDIS & AHCA-Defined	—	51.14%
Follow-Up After ED Visit for Mental Illness[2]			
7-Day Follow-Up	HEDIS	33.05%	28.05%
30-Day Follow-Up	HEDIS	51.14%	45.22%
Follow-Up After ED Visit for AOD Abuse or Dependence[2]			
7-Day Follow-Up—Total	HEDIS	9.69%	5.52%
30-Day Follow-Up—Total	HEDIS	12.30%	8.21%
Antidepressant Medication Management[2]			
Effective Acute Phase Treatment	HEDIS	51.38%	52.58%
Effective Continuation Phase Treatment	HEDIS	35.72%	37.21%

Measure	Measure Source	RY 2017	RY 2018
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	HEDIS	63.31%	62.68%
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Total	HEDIS	38.06%	38.90%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents			
*Total**	HEDIS	1.64%	1.71%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[2]			
Total	HEDIS	—	62.63%
Mental Health Readmission Rate			
*Mental Health Readmission Rate**	AHCA-Defined	33.52%	40.92%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	HEDIS	80.62%	80.75%

** Indicates that lower rates are better for this measure.*
[1] Due to changes in the technical specifications for this measure in RY 2018, NCQA does not recommend trending between RY 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks were not performed for this measure.
[2] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2018 and prior years.
— indicates that the RY 2017 rate is not presented because the MMA plans were not required to report the measure until RY 2018. This symbol may also indicate that NCQA recommended a break in trending; therefore, the RY 2017 rate is not displayed.

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

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

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

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

Results—Access/Availability of Care

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

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

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

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

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

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

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

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

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

Results—Use of Services

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

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

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

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

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

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

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

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

Conclusions and Recommendations

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

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

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

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

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

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

LTC Plans

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

Table 5-8—RY 2018 LTC Performance Measures

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

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

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

Results

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

Table 5-9—Florida Medicaid LTC Program Weighted Averages

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

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

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

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

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

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

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

points, followed by *Care for Adults—Advance Care Planning—Total*, with an increase of approximately 11 percentage points.

Conclusions and Recommendations

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

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

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

6. Performance Improvement Projects

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

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

Table 6-1—Current State-Mandated PIP Topics

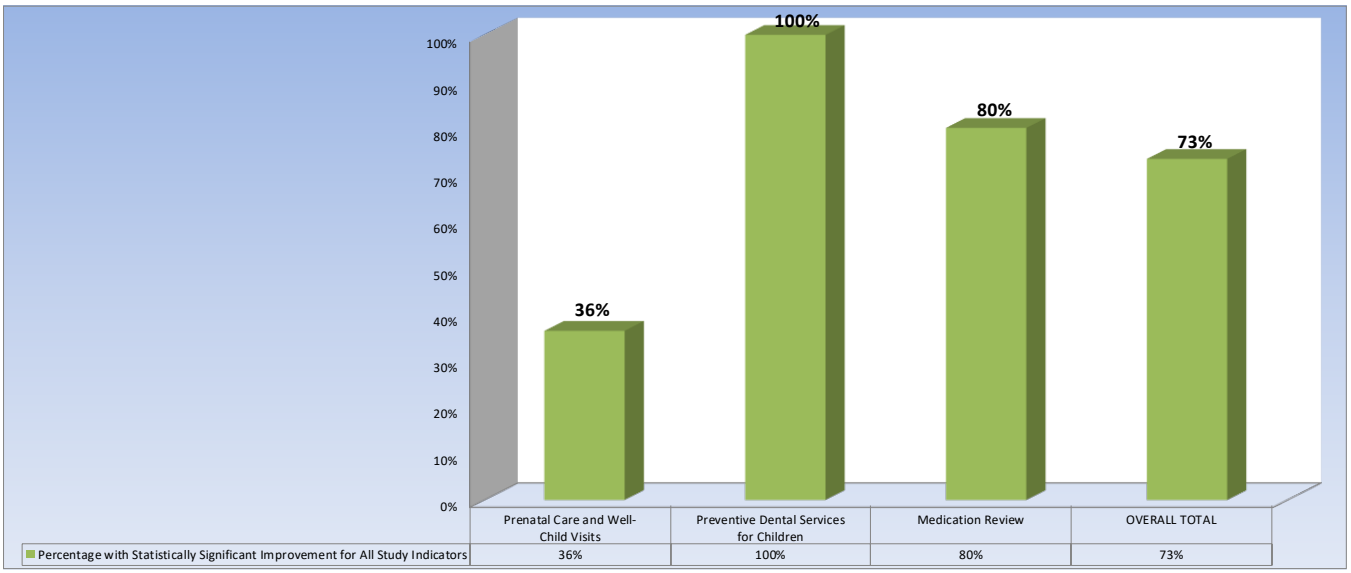
State-mandated PIP Topic	Plan Type	Status
Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	MMA Plans	Remeasurement 2 results reported
Preventive Dental Services for Children	MMA Plans	Remeasurement 2 results reported
Medication Review	LTC Plans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

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

Statistically Significant Improvement

For the SFY 2017–2018 validation cycle, the plans reported Remeasurement 1 and Remeasurement 2 study indicator results, and the PIPs were evaluated for achieving real improvement from baseline to the most recent remeasurement period. The percentages of state-mandated PIPs that demonstrated statistically significant improvement over baseline across all study indicators are presented in **Figure 6-1**.

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

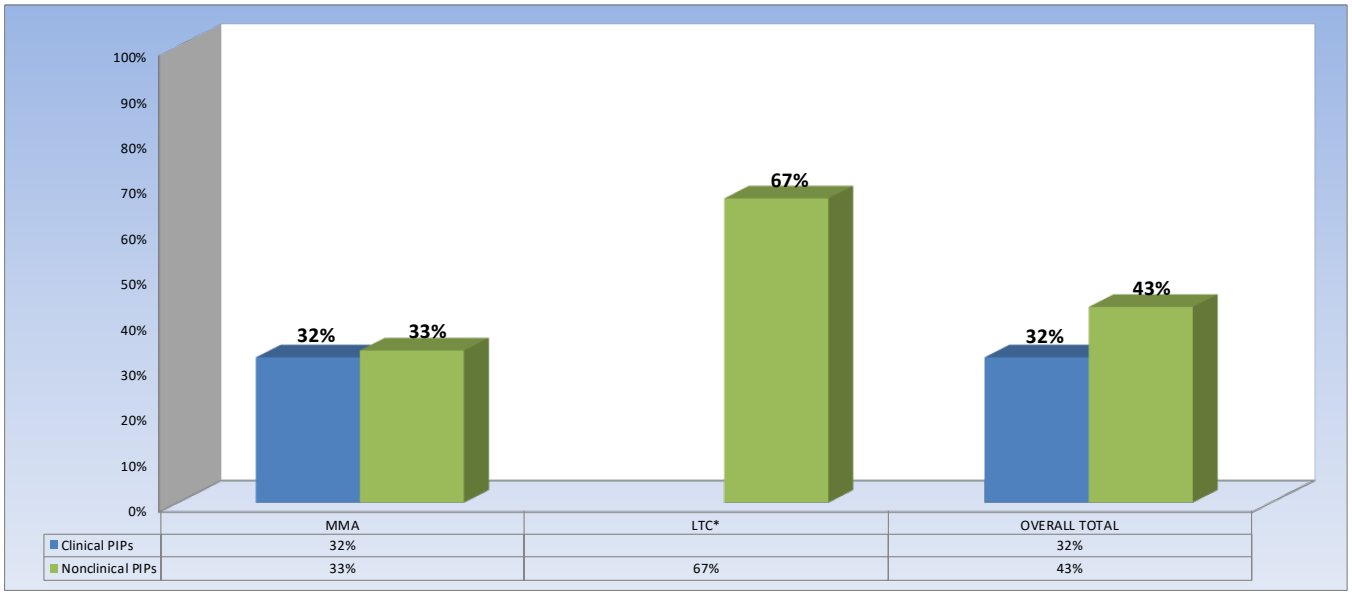


Across the three state-mandated topics, 73 percent of the PIPs demonstrated statistically significant improvement over baseline across all study indicators. The percentage of PIPs demonstrating statistically significant improvement across all study indicators varied by state-mandated topic: 36 percent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

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

In addition to the state-mandated PIPs represented in Figure 6-1, HSAG evaluated the plan-selected clinical and nonclinical PIPs for achieving real improvement across all study indicators. The percentages of plan-selected clinical and nonclinical PIPs that demonstrated statistically significant improvement over baseline across all study indicators are presented in Figure 6-2.

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



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

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

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

Innovative Interventions Associated With Statistically Significant Improvement

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

Overall PIP Validation Status

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

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

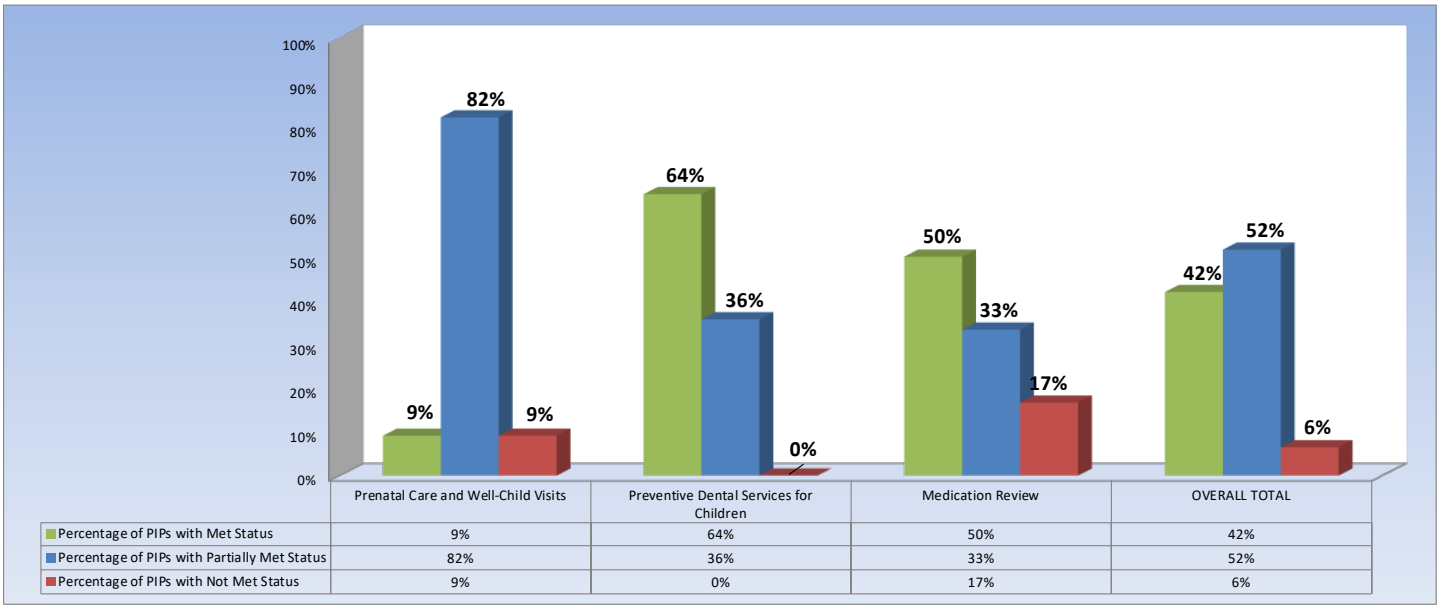
The critical evaluation elements scored when the PIPs progress to the Outcomes stage include one element in Activity VIII (Appropriate Improvement Strategies), one element in Activity IX (Real Improvement),

[6-2] Ibid.

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

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

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



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

Across all state-mandated PIPs, 42 percent received an overall *Met* validation status, 52 percent received an overall *Partially Met* validation status, and 6 percent received a *Not Met* validation status. The percentage of PIPs receiving a *Met* validation status was highest for the *Preventive Dental Services for*

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

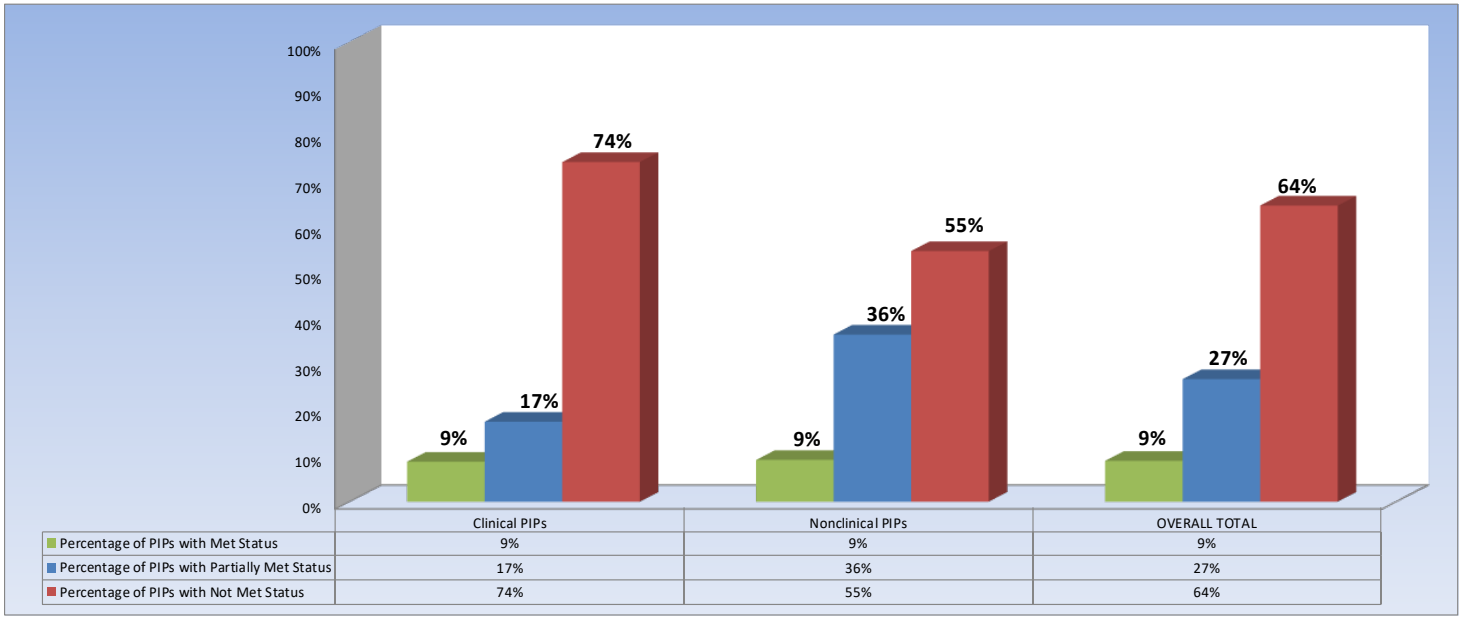
The state-mandated PIPs had progressed through Activity IX or X of the Outcomes stage for this year's validation; therefore, validation status was based on the study design of the PIP, the data analysis and quality improvement (QI) activities conducted for the current period, and whether statistically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

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

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

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

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

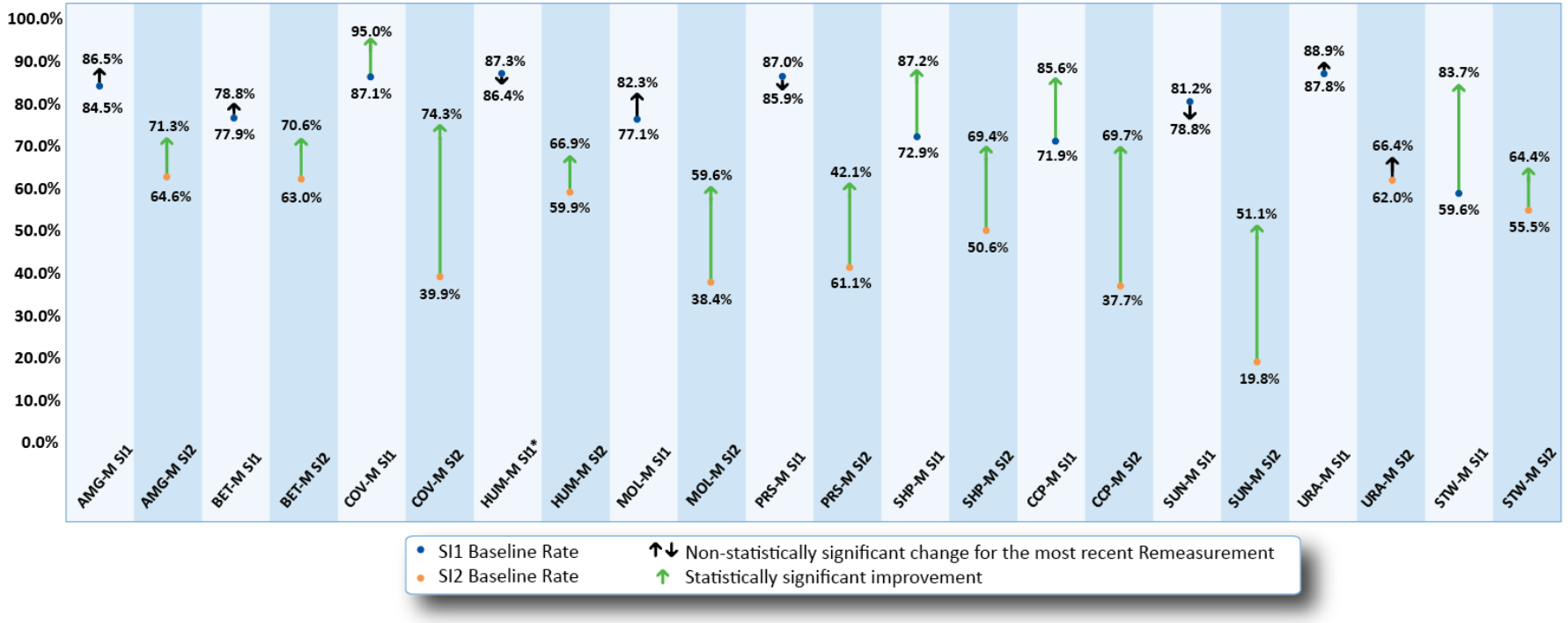


	Clinical PIPs	Nonclinical PIPs	OVERALL TOTAL
Percentage of PIPs with Met Status	9%	9%	9%
Percentage of PIPs with Partially Met Status	17%	36%	27%
Percentage of PIPs with Not Met Status	74%	55%	64%

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

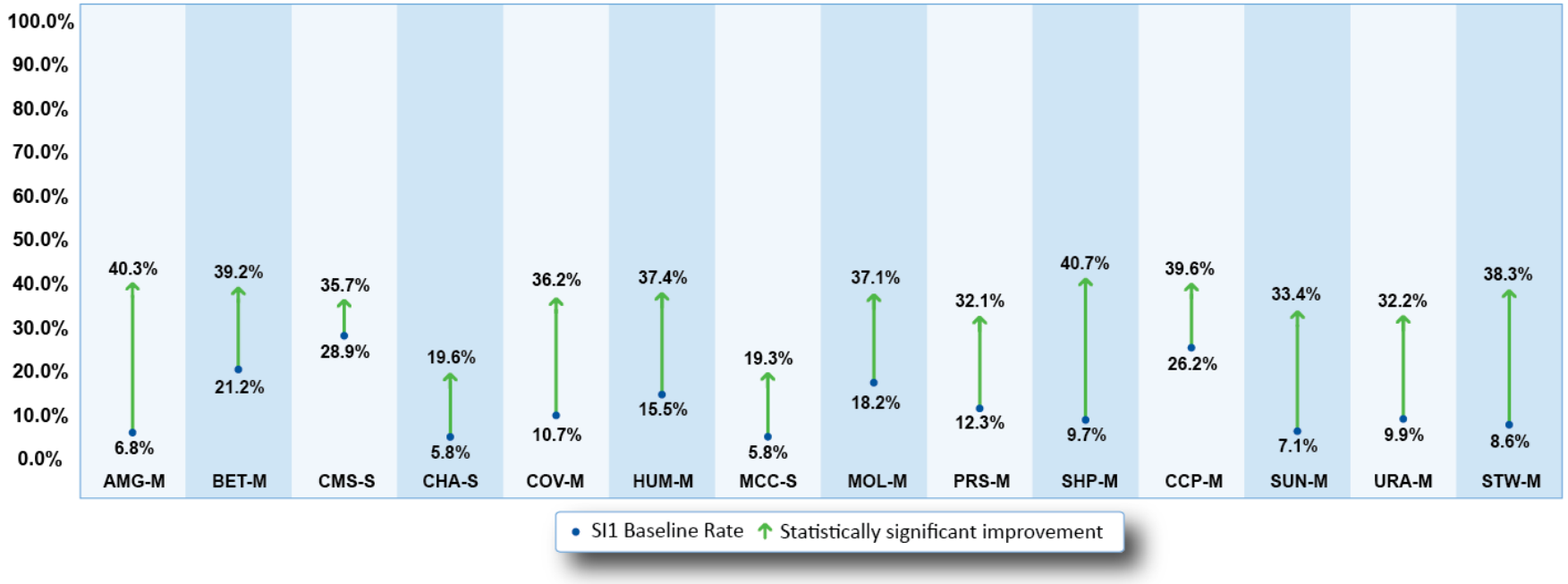
The overall percentage of plan-selected clinical and nonclinical PIPs that received a *Met* validation status (9 percent) was lower than the overall percentage of state-mandated PIP topics that received a *Met* validation status (42 percent, Figure 6-3). This comparison suggests that the plans have more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

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



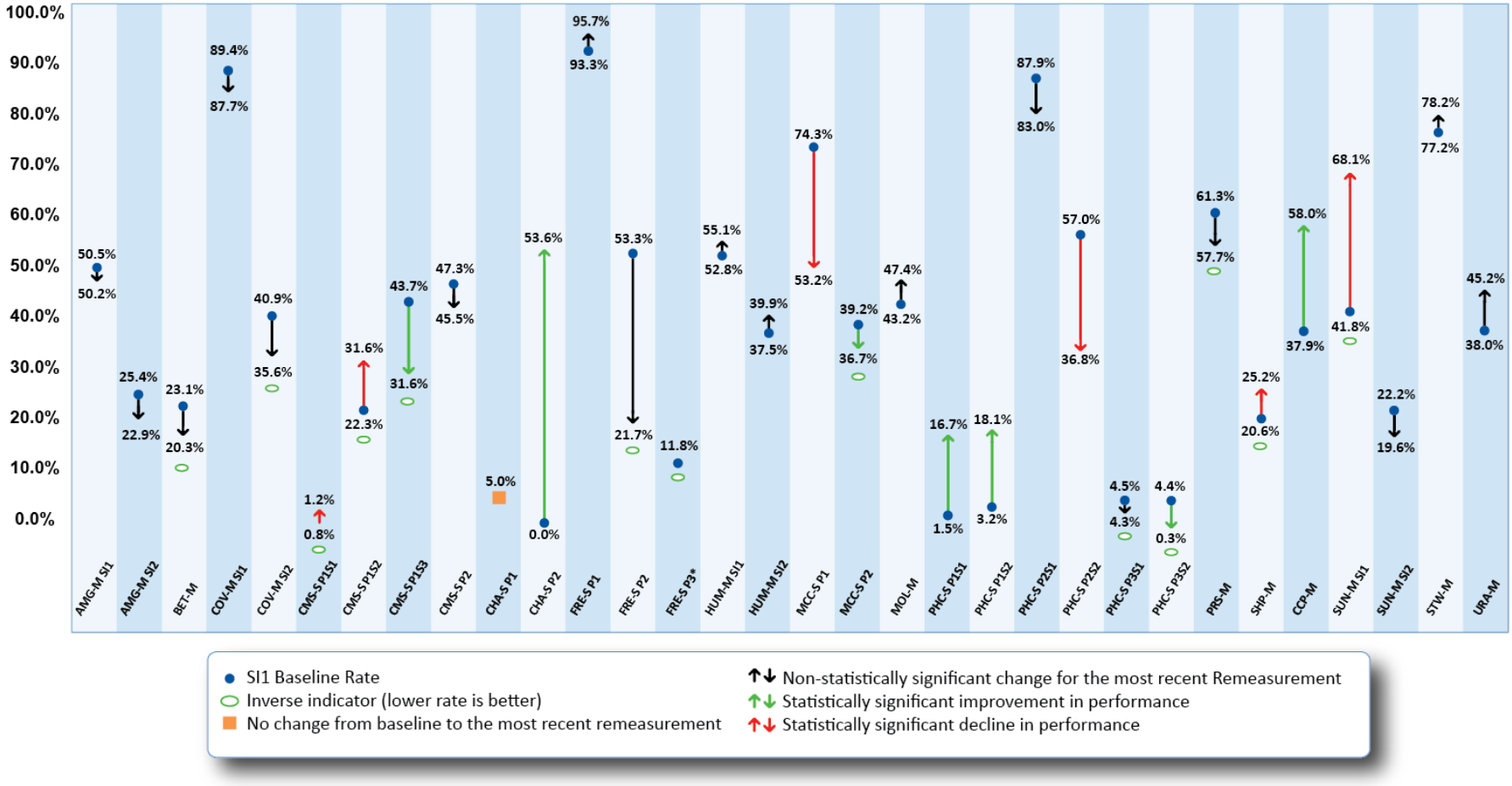
* The plan study indicator labels on the x axis have been abbreviated to the four-letter code to accommodate all the data points.

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



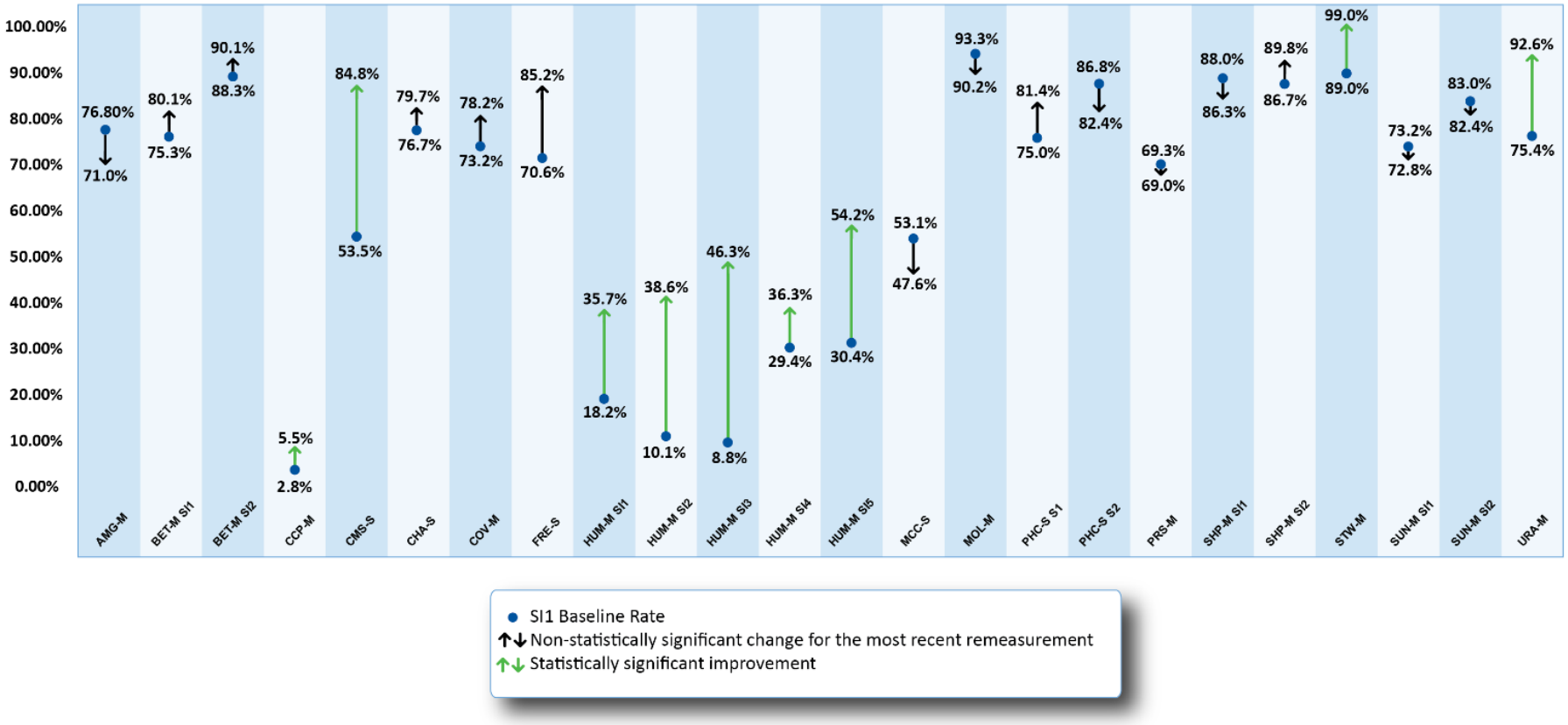
* The plan study indicator labels on the x axis have been abbreviated to the four-letter code to accommodate all the data points.

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



* The plan did not progress to reporting remeasurement results for the current validation cycle.
** The plan study indicator labels on the x axis have been abbreviated to the four-letter code to accommodate all the data points.

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



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

Recommendations

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

Overall recommendations:

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

7. Overall Assessment of Progress in Meeting EQRO Recommendations

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

Table 7-1—HSAG Recommendations With AHCA Actions

HSAG Recommendation	AHCA Action
Performance Improvement Projects	
AHCA should continue the PIP check-in process with each plan. This process helps AHCA more closely monitor each plan's PIP progress and identify opportunities for training and TA. AHCA can refer plans to HSAG for more timely TA, as needed, based on the results of the PIP check-in meetings.	AHCA's PIP Check-in Teams held quarterly meetings with each of the plans throughout the year. AHCA staff asked plans to describe which QI processes and tools they were using and encouraged plans to reach out to HSAG's PIP team and to AHCA for additional TA as needed. HSAG's PIP team provided TA throughout the year to enhance the plans' capacity to implement robust QI processes and strategies for their PIPs. AHCA plans to continue the PIP check-in process.
Continue to explore and identify innovative interventions and share intervention examples with the plans. Sharing potentially promising strategies with the plans may help facilitate improvement in individual PIPs and in statewide efforts.	AHCA staff members continue to compile information on promising interventions to share with the plans. AHCA considers this recommendation completed, as exploring and identifying innovative interventions and sharing interventions are part of regular operations.
Continue to offer and facilitate training and support opportunities to enhance the plans' capacity to implement robust QI processes and strategies for their PIPs. Increasing the plans' efficacy with QI tools such as Plan-Do-Study-Act (PDSA) cycles, especially related to evaluating and refining interventions, should help remove barriers to effectively evaluating improvement strategies and successfully achieving improvement in the PIP study indicators.	AHCA staff members discussed QI processes with the plans during PIP check-in calls during the year. AHCA and HSAG consider this recommendation ongoing.
Validation of Performance Measures	
MMA Plans: During the PMV process, HSAG identified an opportunity to improve clarification of specifications for the *Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk* measure. During the review, HSAG noted that most MMA plans' eligible population values for	AHCA shared HSAG's feedback with CMS on 3/15/17, and CMS responded that it would share the feedback with the measure steward. This is a Child Core Set measure, and AHCA is not responsible for updating the specifications for this

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

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

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

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

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

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

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

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

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

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

Appendix A. Plan Names/Abbreviations

SFY 2017–2018 Plan-Approved Naming Convention

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

Appendix B. MCO PIP Validation Results

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

Table B-1—MMA Plans

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

Plan Name	PIP Topic	Validation Scores and Status
Children's Medical Services Network	*Decreasing Behavioral Health Readmission Rates*	*68% / 58% / Not Met*
	Improving Call Center Timeliness	*70% / 80% /Partially Met*
	Preventive Dental Services for Children	*81% / 91% / Partially Met*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	*80% / 80% / Not Met*
Clear Health Alliance	*Behavioral Health Screening of CHA Members by a PCP*	*82% / 82% / Not Met*
	Improve Member Satisfaction	*88% / 83% / Not Met*
	Improving the Percentage of Enrollees Receiving 2 or More HIV-Related Outpatient Medical Visits at Least 182 Days Apart	*86% / 100% / Met*
	Preventive Dental Services for Children	*86% / 91% / Partially Met*
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Improving Member Management of Diabetes*	*82% / 85% / Not Met*
	Improving Member Satisfaction	*93% / 92% / Not Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*100% / 100% / Met*
	Preventive Dental Services for Children	*100% / 100% / Met*
Freedom Health, Inc.	*Care for Older Adults (COA)—Advance Care Planning*	*75% / 73% / Not Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Poor Control > 9%	*77% / 73% / Not Met*
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	*76% / 73% / Not Met*
	Plan All-Cause Readmissions (PCR)	*88% / 89% / Partially Met*
Humana Medical Plan, Inc.	*Electronic Health Record with Meaningful Use*	*76% / 82% / Partially Met*
	Improving Timeliness of Prenatal Care and Well-Child Visits in the First 15 Months of Life—Six or More Visits	*82% / 77% / Partially Met*
	Integrating Primary Care and Behavioral Health in Antidepressant Medication Management	*85% / 80% / Not Met*
	Preventive Dental Services for Children	*95% / 100% / Met*

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

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

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

Table B-2—LTC Plans

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

Appendix C. PIP Study Indicator Rates

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

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Improving Member Management of Diabetes*	The percentage of enrollees who had an HbA1c test performed during the measurement year.	89.4%	86.6%	87.7%
		The percentage of enrollees who showed poor glycemic control (HbA1c test result > 9%). ↓	40.9%	41.1%*	35.6%
Amerigroup Community Care	*Improving Medication Management for People with Asthma*	The percentage of enrollees who remained on asthma controller medication for at least 50% of their treatment period.	50.5%	46.3%	50.2%
		The percentage of enrollees who remained on asthma controller medication for at least 75% of their treatment.	25.4%	20.6%	22.9%
Better Health	*Reduce All-Cause Hospital Readmissions Within 30 Days*	The percentage of acute inpatient stays for enrollees during the measurement year that were followed by an acute readmission within 30 days for any diagnosis, for enrollees 0 to 64 years of age. ↓	23.1%	21.9%	20.3%
South Florida Community Care Network, d/b/a Community Care Plan	*Increase the Diabetic Retinal Examination Rate for Enrollees*	The percentage of enrollees age 18 to 75 with diabetes (type 1 and type 2), assigned to a PCP in one of the targeted cities, who had a diabetic retinal examination performed in the measurement year or had a negative result for a diabetic retinal examination during the year prior to the measurement year.	37.9%	58.0%*	NR

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Children's Medical Services Network	*Decreasing Behavioral Health Readmission Rates*	The rate of children who are admitted to an inpatient facility for a mental or behavioral health issue. ↓	0.8%	1.2%	1.2%
		The rate of children who are readmitted to an inpatient facility (meaning admitted and readmitted during the same period) for a mental or behavioral health issue. ↓	22.3%	36.3%	31.6%
		The rate of children who are readmitted for a mental of behavioral health issue more than twice (meaning admitted and readmitted two or more times during the same period, for a total of three or more admissions) to an inpatient facility. ↓	43.7%	53.0%	31.6%*
	Well-Child Visits in the First 15 Months of Life—Six or More Visits	The percentage of enrollees who had six well-child visits by the first 15 months of life.	47.3%	41.8%	45.5%
Clear Health Alliance	*Behavioral Health Screening of CHA Members by a PCP*	The percentage of Clear Health-S enrollees who received an annual behavioral health screen by their PCP.	5.0%	6.2%*	5.0%
	Improving the Percentage of Enrollees Receiving 2 or More HIV-Related Outpatient Medical Visits at Least 182 Days Apart	The percentage of enrollees diagnosed with HIV/AIDS who were seen on an outpatient basis by a physician, physician assistant, or advanced registered nurse practitioner for two HIV-related medical visits at least 182 days apart within the measurement year.	0.0%	35.2%*	53.6%**
Freedom Health, Inc.	*Comprehensive Diabetes Care (CDC)—HbA1c Poor Control > 9%*	The percentage of plan enrollees 18–75 years of age with a diagnosis of diabetes (Type I and Type II) who had HbA1c poor control > 9% during the measurement year. ↓	53.3%	21.7%	NR

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
	Comprehensive Diabetes Care (CDC)—HbA1c Testing	The percentage of plan enrollees 18–75 years of age with a diagnosis of diabetes (Type I and Type II) who had HbA1c testing during the measurement year.	93.3%	95.7%	NR
	Plan All-Cause Readmissions (PCR)	The percentage of plan enrollees less than 65 years of age with an unplanned acute readmission for any diagnosis within 30 days of being discharged from an acute inpatient hospital stay. ↓	11.8%	NR	NR
Humana Medical Plan, Inc.	*Integrating Primary Care and Behavioral Health in Antidepressant Medication Management*	The percentage of eligible enrollees who remained on an antidepressant medication treatment for at least 84 days during the measurement year.	52.8%	54.3%	55.1%
		The percentage of eligible enrollees who remained on an antidepressant medication treatment for at least 180 days during the measurement year.	37.5%	38.7%	39.9%
Magellan Complete Care	*Improving Diabetes Screening Rates for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	The percentage of enrollees with schizophrenia or bipolar disorder, using antipsychotic medications, who complete a diabetes screening in Regions 10 and 11.	74.3%	53.2%	NR
	Plan All-Cause Readmissions (PCR)	Percentage of enrollees who had an acute inpatient stay followed by an unplanned acute readmission for any medical or behavioral health diagnosis within 30 days. ↓	39.2%	36.7%*	NR
Molina Healthcare of Florida, Inc.	*Improving the Rate of Asthmatic Children Using Controller Medications*	The percentage of enrollees 5 to 18 years who were identified as having persistent asthma and remained on an asthma controller medication for at least 50 percent of the treatment period.	43.2%	42.7%	47.4%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
AHF MCO of Florida, Inc. d/b/a Positive Healthcare, Inc.	*7- and 30-Day Follow-up After a Hospitalization for a Mental Illness*	The percent of acute care facility discharges for enrollees hospitalized for a mental health diagnosis, discharged to the community, and seen on an outpatient basis by a mental health practitioner within seven days.	1.5%	0.0%	16.7%*
		The percent of acute care facility discharges for enrollees hospitalized for a mental health diagnosis, discharged to the community, and seen on an outpatient basis by a mental health practitioner within 30 days.	3.2%	0.0%	18.1%*
	Improving Rates of CD4 and Viral Load Testing	The percentage of stable enrollees who get at least two CD4 and viral load (VL) tests during the measurement year.	87.9%	83.6%	83.0%
		The percentage of enrollees with a detectable VL in the previous two years, receiving at least three CD4 and viral load tests during the measurement year.	57.0%	42.9%	36.8%
	Reducing Avoidable Emergency Room Visits	Percentage of avoidable emergency department visits for plan enrollees during the measurement year. ↓	4.5%	3.8%	4.3%
		Percentage of avoidable emergency department visits with ICD 9 [International Classification of Diseases, Ninth Revision] codes selected for persons living with HIV/AIDS. ↓	4.4%	3.3%	0.3%*
Prestige Health Choice	*Improve Rates for HbA1c Testing and Compliance Among Diabetics*	The percentage of diabetic enrollees 18 to 50 years of age who had an HbA1c test result > 9 or were missing an HbA1c test result within the measurement year. ↓	61.3%	50.8%*	57.7%

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

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

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

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

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

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

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Improving Member Satisfaction*	The percentage of eligible enrollees who responded with a score of 8 or higher to the overall plan satisfaction CAHPS 5.0 Survey question.	73.2%	77.2%	78.2%
Amerigroup Community Care	*Improving Overall Member Satisfaction*	The percent of enrollees who respond 8, 9, or 10 on Question #35, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"	76.8%	76.8%	71.0%
Better Health	*Improve Member Satisfaction*	The percentage of enrollees who responded to the overall plan satisfaction CAHPS 5.0 Adult survey question with a score of 8 or higher.	75.3%	79.2%	80.1%
		The percentage of enrollees who responded to the overall plan satisfaction CAHPS 5.0 Child survey question with a score of 8 or higher.	88.3%	86.6%	90.1%
Children's Medical Services Network	*Improving Call Center Timeliness*	The percentage of calls received during the measurement year that were answered by a live voice within 30 seconds.	53.5%	54.0%	84.8%*
Clear Health Alliance	*Improve Member Satisfaction*	The percentage of enrollees who responded to the overall plan satisfaction CAHPS 5.0 question with a score of 8 or higher.	76.7%	76.2%	79.7%*
South Florida Community Care Network, d/b/a Community Care Plan	*Improving the Number of Health Risk Assessments*	The percentage of returned and completed health risk assessments for new members.	2.8%	5.5%*	5.5%**

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Freedom Health, Inc.	*Care for Older Adults (COA)—Advance Care Planning*	The percentage of enrollees 66 years of age and older as of December 31 of the measurement year who had evidence of advance care planning during the measurement year.	70.6%	85.2%	NR
Humana Medical Plan, Inc.	*Electronic Health Record with Meaningful Use*	The percentage of eligible providers in Region 11 who reported using an Electronic Health Record in a meaningful use manner.	18.2%	23.8%*	35.7%**
		The percentage of eligible providers in Region 10 who reported using an Electronic Health Record in a meaningful use manner.	10.1%	30.1%*	38.6%**
		The percentage of eligible providers in Region 9 who reported using an Electronic Health Record in a meaningful use manner.	8.8%	34.0%*	46.3%**
		The percentage of eligible providers in Region 6 who reported using an Electronic Health Record in a meaningful use manner.	29.4%	24.9%	36.3%*
		The percentage of eligible providers in Region 1 who reported using an Electronic Health Record in a meaningful use manner.	30.4%	38.4%*	54.2%**
Magellan Complete Care	*Increase the Rate of Adult Member's Overall Satisfaction (CAHPS)*	The percentage of CAHPS adult survey respondents who respond to the question, "How would you rate your health plan" with a score of 9 or 10.	53.1%	51.0%	47.6%
Molina Healthcare of Florida, Inc.	*Practitioner Satisfaction*	The percentage of practitioners surveyed who responded "very satisfied" or "somewhat satisfied" to overall satisfaction with Molina.	93.3%	91.2%	90.2%

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
AHF MCO of Florida, Inc. d/b/a Positive Healthcare, Inc.	*Improving Satisfaction with Cultural and Language Services for People Living with HIV/AIDS*	The percentage of enrollees who report usually or always receiving health care services in a language they could understand.	75.0%	77.7%	81.4%
		The percentage of enrollees who report usually or always feeling that the health care staff was sensitive to their cultural needs.	86.8%	84.0%	82.4%
Prestige Health Choice	*Overall Health Plan Rating Via CAHPS® 5.0H Adult Medicaid Survey*	The percentage of enrollees that responded to the CAHPS 5.0H Adult Medicaid survey on Rating of Health Plan with a rank of 8, 9, or 10 on a 10-point scale.	69.3%	65.8%	69.0%
Simply Healthcare Plans, Inc.	*Improve Member Satisfaction*	The percentage of adult enrollees who responded with a score of 8 or higher to the overall plan satisfaction CAHPS 5.0 survey question.	88.0%	83.7%	86.3%
		The percentage of child enrollees who responded with a score of 8 or higher to the overall plan satisfaction CAHPS 5.0 survey question.	86.7%	85.1%	89.8%
Wellcare d/b/a Staywell Health Plan of Florida, Inc.	*Call Answer Timeliness*	The percentage of calls received by the plan's Member Services call center (during operating hours) during the measurement year that were answered by a live voice within 30 seconds.	89.0%	80.7%	99.0%*
Sunshine State Health Plan, Inc.	*Member Satisfaction*	The percentage of enrollees who responded to the CAHPS 5.0 Survey Question 35 with a score of 8 or higher.	73.2%	72.8%	NR
		The percentage of enrollees who responded to the CAHPS 5.0 Survey Question 36 with a score of 8 or higher.	83.0%	82.4%	NR

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
UnitedHealthcare of Florida, Inc.	*Call Answer Timeliness and Call Abandonment (CAT-CAB)*	The percentage of calls answered by a live voice within 30 seconds.	75.4%	91.6%*	92.6%**

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

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

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

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

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
Coventry Health Care of Florida, Inc., d/b/a Aetna Better Health of Florida, Inc.	*Timeliness of Services for the Long-Term Care Program*	The percentage of newly enrolled enrollees who received home health services, adult day care and/or home-delivered meals within 8 business days from the effective date of enrollment.	50.9%	52.8%	81.5%*
		The percentage of newly enrolled enrollees who received home health services within 8 business days from the effective date of enrollment.	62.9%	56.7%	78.2%*
		The percentage of newly enrolled enrollees who received adult day care services within 8 business days from the effective date of enrollment.	54.3%	68.6%*	90.8%*
		The percentage of newly enrolled enrollees who received home-delivered meal services within 8 business days from the effective date of enrollment.	18.7%	36.1%*	80.6%*
Amerigroup Community Care	*Improving the Number of Members with Advance Directives*	The percentage of enrollees who have evidence of advanced care planning in their case records during the measurement year.	73.1%	97.7%*	90.5%**
Humana Medical Plan, Inc.	*Person-centered Care Plan*	The percentage of eligible enrollees that have at least four person-centered care plan updates documented.	53.0%	76.4%*	75.6%**
Molina Healthcare of Florida, Inc.	*Provider Satisfaction*	The percent of providers surveyed who responded “satisfied” or “somewhat satisfied” to overall satisfaction with Molina.	87.0%	85.2%	85.1%
Sunshine State Health Plan, Inc.	*Timeliness of Services*	Newly enrolled (eligible) LTC enrollees who receive home health services, or adult day health, or home-delivered meals within 3 calendar days from the effective date of enrollment.	37.2%	32.8%+	55.1%*+

Plan Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Remeasurement 2 Rate
UnitedHealthcare of Florida, Inc.	*Documentation of an Advance Directive*	The percentage of eligible enrollees who complete an Advance Directive during the measurement year.	63.6%	62.6%	59.9%

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

Appendix D. MCO Performance Measure Results

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

Pediatric Care Domain

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

Table D-1—Pediatric Domain Performance Measure Abbreviations

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

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

Table D-2—Pediatric Care Domain Performance Measure Results

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

** Indicates that lower rates are better for this measure.*
[1] Due to changes in the technical specifications for this measure, a comparison to benchmarks was not performed; therefore, the rates in the table above are presented for information only.
[2] AHCA did not set a performance target for this measure for RY 2018.
NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.
Freedom-S was not required to report rates on Pediatric Care measures; therefore, the MMA is excluded from the table.
Although Positive-S reported the required Pediatric Care measures, the MMA is excluded from the table due to reporting rates of "NA" for all Pediatric Care measures based on small denominators.

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

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

Women's Care Domain

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

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

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

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

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

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

[1] Due to changes in the technical specifications for this measure, a comparison to benchmarks was not performed; therefore, the rates in the table above are presented for information only.
[2] AHCA did not set a performance target for this measure for RY 2018.
NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.
— indicates that the MMA was not required to report a rate for the measure.
Although Freedom-S reported the required Women's Care measures, the MMA was excluded from the table due to reporting rates of "NA" for all Women's Care measures based on small denominators.

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

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

Living With Illness Domain

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

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

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

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

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

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

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

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

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

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

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

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

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

Behavioral Health Domain

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

Table D-7—Behavioral Health Domain Performance Measure Abbreviations

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

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

Table D-8—Behavioral Health Domain Performance Measure Results

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

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

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

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

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

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

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

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

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

Access/Availability of Care Domain

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

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

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

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

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

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

NA indicates that the MMA followed the specifications, but the denominator was too small (<30) to report a valid rate.
— indicates that the MMA was not required to report a rate for the measure.

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

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

Use of Services Domain

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

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

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

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

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

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

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

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

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

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

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

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

LTC Plan-Specific Results

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

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

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

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

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

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

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

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

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

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

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